ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Office of Health Protection, Division of Infectious Diseases, HIV/AIDS Section

2015-2016 HIV Prevention Intervention & Strategy Guidance for IDPH HIV Prevention Grantees

I&S Committee Recommendations

Presented to ILHPG August 28, 2015

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Office of Health Protection, Division of Infectious Diseases, HIV/AIDS Section
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for IDPH HIV Prevention Grantees

Applicant Eligibility Criteria

- Only organizations based within Illinois are eligible to receive HIV Prevention grant funds.
- Applicant organizations may be local health departments or not-for-profit private community-based organizations including volunteer or religious organizations which effectively engage prioritized risk populations including gay or bisexually-active males, high risk heterosexual women and men, and current or former users of injection drugs, particularly those who are also racial or ethnic minorities impacted by poverty.
- Applicants must provide proof that their organizational registration with the Illinois Secretary of State is currently in good standing.
- Applicants must have paid all due County, State and Federal Taxes or have an approved payment plan in place.
- Applicants may not be a 501(c) (4) organization, or an organization whose primary mission is to engage in Illinois or federal lobbying activities.
- Applicant organizations may not been convicted of bribing or attempting to bribe an officer or employee of the State of Illinois or any other State, nor has made an admission on the record of having so bribed or attempted to bribe (30 ILCS 500/50-5).
- If the applicant organization has been convicted of a felony, at least five years must have passed after the date of completion of the sentence for such felony, unless no person held responsible by a prosecutor's office for the facts upon which the conviction was based continues to have any involvement with the business (30 ILCS 500/50-10).
- If the applicant organization, or any officer, director, partner, or other managerial agent, has been convicted of a felony under the Sarbanes-Oxley Act of 2002, or a Class 3 or Class 2 felony under the Illinois Securities Law of 1953, at least 5 years have passed since the date of the conviction. (30 ILCS 500/50-10.5).

Grantee Legal Requirements

- The grantee organization and its affiliates may not be delinquent in the payment of any debt to the State (or if delinquent has entered into a deferred payment plan to pay the debt). (30 ILCS 500/50-11)
- The grantee organization may not have committed a willful or knowing violation of the Environmental Protection Act (relating to Civil Penalties under the Environmental Protection Act) within the last five (5) years. (30 ILCS 500/50-14).
- The grantee organization may not have paid any money or valuable thing to induce anyone to refrain from bidding on a State Grant, nor accepted any money or valuable thing, or acted upon the promise of same, for not bidding on a State Grant (30 ILCS 500/50-25).
- The grantee organization may not have violated the "Revolving Door" section of the Illinois Procurement Code (30 ILCS500/50-30).

- The grantee organization may not have been convicted of the offense of bid rigging or bid rotating or any similar offense of any State or of the United States (720 ILCS 5/33E-3, 5/33E-4).
- The grantee organization may not have violated Section 50-14.5 of the Illinois Procurement Code (30 ILCCS 500/50-14.5) that states: "Owners of residential buildings who have committed a willful or knowing violation of the Lead Poisoning Prevention Act (410 ILCS 45) are prohibited from doing business with the State until the violation is mitigated".
- The grantee organization may not be in default on an educational loan (5 ILCS 385/3).

Grantee Equipment Requirements

- Grantee organizations must possess or budget to acquire computer equipment meeting the minimal technical requirements for the Department's electronic Prevention Evaluation Monitoring System supported by Provide® Enterprise:
    - A PC computer (not Apple Macs or Unix-Based Workstations) capable of running XP, Windows Vista, or Windows 7 with all Windows Updates applied
    - An internet connection (high-speed or broadband strongly encouraged);
    - Suggested PC configuration -
        - minimal 128 MB of RAM
        - minimal Pentium 3, 600 MHz processor or equivalent
        - 8 GB hard drive
        - Super VGA or better monitor, minimum resolution 800x600, 256 colors
    - Agency Firewall opened to allow outbound TCP traffic on Port 1433
    - Administrative Access to install software on the computer
    - A document scanner connected to the computer running Provide® Enterprise with a TWAIN-compliant printer to allow the direct scanning of documents into Provide® Enterprise (rather than scanning outside of Provide® and then attaching as a file).
        - Scanner Requirements: Any type of scanner that can save scanned images to a standard format like PDF or JPG or TIF.
        - Scanner Optimal Recommendations:
            - Scanner should be direct-PC attached or network-attached to the PC where the Provide® Enterprise installation exists
            - Optional features that may be helpful include the following.
            - Duplex scanning to capture both the front and back of two-sided forms
            - A scanner accepting various document sizes and types (legal size, photo, etc)
            - An auto-feed to capture a stack of forms

Developing High Impact Prevention Grant Proposals

The Centers for Disease Control and Prevention (CDC) promotes the implementation of High Impact Prevention strategies and interventions to achieve the National HIV AIDS Strategy (NHAS) goals as follow.

- Reduce the number of new HIV infections.
- Increase access to care and improve health outcomes for people living with HIV.
- Reduce HIV-related health disparities.

High-Impact Prevention (HIP) maximizes the impact of limited resources to reduce new HIV infection rates by combining cost-effective public health strategies and interventions to target the highest risk populations in the most affected geographic areas. HIP proposals incorporate strategies and interventions that meet the following criteria:

- Most cost-effective for reducing new HIV infections
- Practical to implement with target populations on a large-scale at reasonable cost
- Strategies and interventions strategically combined for greater impact

CDC estimates of cost-effectiveness by service type and risk group are listed in the table below. Programs that identify PWHIV, link them to HIV treatment, and support their HIV medication adherence have the highest impact, costing the least per new HIV infections averted. Effective behavioral interventions with PWHIV to reduce their transmission risks are the next most cost-effective, followed by behavioral interventions with prioritized high risk negatives. Biomedical interventions with prioritized risk negatives cost the most per infection averted for any given risk group, though they vary considerably by risk in cost per infection averted.

Estimated Cost per Infection Averted in US dollars

Untargeted interventions	**Cost per new infection averted**		
Testing in clinical settings	$51,000		
Partner services	$99,000		
Linkage to care	$115,000		
Retention in care	$76,000		
Adherence to ART	$43,000		
Targeted Interventions	**Heterosexual**	**IDU**	**MSM**
Testing in non-clinical settings	$866,000	$54,000	$18,000
Behavioral intervention for HIV+ people	$595,000	$700,000	$97,000
Behavioral intervention for HIV- people	$15,600,000	$2,900,000	$300,000
Pre-exposure prophylaxis (PrEP)	$170,000,000	$900,000	$700,000

Source: *High Impact HIV Prevention Services and Best Practices*, slide 19, Presentation at HIV Prevention Project Annual Technical Support Meeting, December 4, 2013, Washington, DC, Presenter, David W. Purcell, JD, PhD, Deputy Director for Behavioral and Social Science, Division of HIV/AIDS Prevention, Centers for Disease Control and Prevention.

Interventions and Strategies Categories

Interventions and Strategies may be categorized as follows:

1) Recruitment Strategies
2) Key Public Health Strategies
3) Behavioral Risk Reduction Interventions
   a. CDC-Supported Effective Behavioral Interventions
   b. CDC-Unsupported Effective Behavioral Interventions
   c. Locally Developed Interventions with Evidence of Effectiveness
   d. Unvetted Behavioral Interventions
4) Biomedical Risk Reduction Interventions
   a. Evidence-Based Linkage-Retention-Reengagement in Care (LRRC) Interventions for Positives
   b. Biomedical Risk Reduction interventions for High Risk Negatives

Recruitment Strategies

Many interventions, in order to achieve cost effectiveness require the targeting of groups very likely to transmit or acquire HIV infection. Strategies to selectively engage prioritized risk populations into prevention services are called recruitment strategies. *Recruitment strategies in their own right do not reduce HIV risk and are not fundable as services*, but should be used in conjunction with funded strategies and interventions to maximize the HIV prevention impact of the service. Recruitment strategies include but are not limited to the following

- Outreach services delivered at the natural gathering sites of prioritized risk groups, that is, sites where the majority of persons gathered have the targeted risk (e.g. offering HIV testing at a methadone clinic to reach persons with injection drug use history)
- Brief pre-screening of clients at general public gathering sites in order to selectively promote prevention services to those disclosing prioritized risk while offering of condoms and literature to people who disclose lower risk behaviors
- Incentivizing target population organizations to create special social events at which prevention services occur
- Social Networking Strategy provides short-term coaching and stipends to clients with HIV-positive serostatus and/or with prioritized risk histories to recruit high risk members of their own personal social networks to participate in prevention services. For information, see https://effectiveinterventions.cdc.gov/en/HighImpactPrevention/PublicHealthStrategies/SocialNetworkStrategy.aspx
- Individual-level social media recruitment via personal invitations sent through social media websites or mobile phone applications with messaging features to individuals whose profiles suggest a likely high risk behavioral history
- Risk-targeted advertising conveyed through websites or mobile phone applications predominantly utilized by a prioritized risk group
- Selective referrals from other providers of their clients who disclose prioritized risks

Key Public Health Strategies

- Key Public Health Strategies may be used to target all prioritized risk, race and age groups with the following two exceptions:
  - HIV Counseling, Testing and Referral services (HCTR) may be used only with persons who are HIV-negative, HIV-unknown or HIV-indeterminate in serostatus.
  - Harm Reduction Counseling (HRC) including syringe exchange and over dose prevention may be provided only for persons with past Injection Drug User (IDU) risk.
- Risk-targeted HIV Counseling and Testing
  - Risk-targeted HIV Counseling and testing focuses on specific populations shown to be at greater risk for acquiring HIV according to HIV surveillance or HIV testing data.
  - New HIV diagnoses are maximized by screening individuals disclosing risks associated with higher HIV seropositivity rates.
  - Though marketing is targeted, clients requesting testing will not be turned away even if they disclose no prioritized risks.
  - Either providers or clients may initiate testing.
  - Client level data collected includes risk history and demographic information
  - Client consent to test must be documented in the testing record and a signed release of information from the client allowing quality assurance reviews is required.
- Routine HIV Testing
  - Routine testing is recommended for all persons for HIV between the ages of 13-64 in all healthcare settings per the 2006 CDC testing guidelines and recommendations.
  - In healthcare settings which adopt routine HIV testing, all clinic patients aged 13-64 are informed they will be tested unless they decline the test and then provided an HIV test once as part of general medical care unless they opt out. Patients known to be at higher risk clients are recommended to have subsequent annual HIV testing.
  - Verbal consent is legally sufficient and must be documented in the patient's medical record.
  - Routine testing collects risk behavior information only from clients who test HIV-positive.

Behavioral Risk Reduction Interventions

CDC-Supported Behavioral Interventions

Supported Interventions are cost-effective, evidence-based programs estimated by the CDC to avert HIV infections at a cost of less than $402,000, the estimated cost of lifetime HIV treatment for one HIV-infected individual. These estimates are based on the intervention's measured risk reduction efficacy, the cost of delivering one complete intervention to one target population member, and the targeted population's estimated HIV incidence or HIV transmission rates. CDC Estimated Cost per Infection Averted for serostatus and risk groups by intervention categories are presented in the table on Page 3. Specific supported and unsupported interventions are listed below. As population factors are critical to these estimates, an intervention may be supported for one population but not for another. Funding and implementing CDC-Supported Behavioral Interventions should be prioritized above interventions lacking evidence of cost-effective (e.g., CDC-Unsupported Interventions) or rigorous evidence of effectiveness (e.g. Locally Developed Interventions with Evidence of Effectiveness or Unvetted Interventions) whenever logistically possible.

CDC Division of HIV/AIDS Prevention Interventions Categorizations

CDC-Supported HIV Prevention Interventions

- People Living With HIV (PLWH)
  - CLEAR
  - Healthy Relationships
  - Partnership for Health
  - WILLOW
  - CONNECT adapted for HIV discordant couples
  - START adapted for newly released HIV positive prisoners
- IDU
  - PROMISE
- Women
  - PROMISE
  - Sister to Sister
- MSM
  - d-up!
  - Mpowerment
  - 3MV
  - POL
  - PCC
  - PROMISE
  - VOICES/VOCES
- General Population
  - Safe in the City
- High-risk youth
  - PROMISE
- Transgender populations
  - Any of the EBIs in the CDC's Compendium of Effective Behavioral Interventions may be adapted for transgender persons

CDC-Unsupported HIV Prevention Behavioral Interventions

- Adult Identity Mentoring (AIM)
- Cuidate
- Modelo Intervencion Psichomedica
- NIA
- Real AIDS Prevention Project (RAPP)
- Respect
- Safety Counts
- SHIELD
- SIHLE
- SISTA
- Street Smart
- VOICES/VOCES (except when used with MSM)

CDC-Unsupported Interventions

These behavioral interventions (listed above on Pg 6) are no longer to be supported with CDC funding or supported with CDC-sponsored training due to their poor cost-effectiveness. Their low cost effectiveness may be due to the intervention producing small and/or unsustained reductions in risk behavior--particularly in populations with low HIV incidence rates--resulting in very few infections being prevented. In the case of the one-session Respect intervention, CDC support was withdrawn due to new evidence showing no reduction of risk for any population and increase in risk for one risk group. Unsupported interventions may be funded for grants supported partly or fully by State of Illinois General Revenue Funds if no *CDC-supported* intervention for the prioritized risk population to be served is available. In fact, in this circumstance, CDC-Unsupported Behavioral Interventions should be prioritized above interventions lacking rigorous evidence of effectiveness (e.g. Locally Developed Interventions with Evidence of Effectiveness or Unvetted Interventions) whenever logistically possible. CDC may maintain on-line training and downloadable implementation materials on www.effectiveinterventions.org for some of these Unsupported interventions. Questions about this issue should be addressed to interventions@danya.com.

Locally Developed Interventions with Evidence of Effectiveness

These interventions must (1) have been developed by Illinois providers, (2) have well defined curricula, (3) have been evaluated finding some evidence of effectiveness; however, the evaluation was insufficiently rigorous to meet CDC standards for either Effective Behavioral Intervention or CDC-Supported status.

Unvetted Behavioral Interventions

These locally conducted interventions lack one or both of the following: a well-defined curriculum and an evaluation finding evidence of effectiveness in a sustained reduction in client risk following the intervention. Grantees should not invest prevention resources in services lacking a clear service protocol or lacking evidence of risk reduction attributable to that protocol when cost-effective or simply effective curricula could be implemented.

Biomedical Risk Reduction Interventions for Positives

Biomedical Interventions use medical, clinical, and public health approaches designed to moderate biological and physiological factors to prevent HIV infection, reduce susceptibility to HIV and/or decrease HIV infectiousness.

Evidence-Based Linkage-Retention-Reengagement in Care Interventions for Positives

LRRC Evidence-Based Interventions

Linkage-Retention-Reengagement in Care (LRRC) Evidence-Based Interventions (EBIs) have been tested with a comparison group, have been rigorously evaluated, and have shown significant effects in improving linkage to, retention in, or re-engagement in HIV medical care among persons living with HIV. These interventions are considered to be scientifically rigorous and provide the strongest evidence of efficacy. Descriptions of these interventions may be found at http://www.cdc.gov/hiv/prevention/research/compendium/lrc/index.html. The LRRC

intervention prioritized for Department-funded prevention providers in 2016 is the **Antiretroviral Treatment Access Study (ARTAS)** intervention. The other LRRC EBIs are designed to be implemented within HIV medical treatment programs by clinical staff and documented within the Care case management or medical record, therefore, if funded, may need to be documented as Care services and monitored by the HIV Ryan White Direct Services Unit. In 2016, the HIV Prevention Unit will collaborate with the Direct Services Unit and the Illinois HIV Planning Group to determine which of these new LRRC interventions should be prioritized for 2017 and the optimal means of funding and documenting them.

Biomedical Risk Reduction interventions for High Risk Negatives

Pre-Exposure Prophylaxis

Pre-exposure prophylaxis (PrEP) is the daily use of anti-retroviral HIV medication by HIV-negative persons at substantial risk for HIV infection to prevent HIV infection. The medication (brand name Truvada) approved by the US Public Health Service for PrEP contains two drugs (tenofovir and emtricitabine) that are used in combination with other medicines to treat HIV. When an individual is exposed to HIV through sex or injection drug use, these medicines reduce the likelihood that HIV will establish a permanent infection. The level of effectiveness is dependent upon medication adherence consistency. PrEP is recommended for use in combination with condoms and other prevention methods.

Note: For prevention providers, PrEP is a risk reduction *method* option involving a medical referral that may be offered for a client's consideration as individually appropriate during *any* public health strategy or risk reduction activity and documented as an activity and referral for that session.

Non-Occupational Post-Exposure Prophylaxis

Nonoccupational Postexposure Prophylaxis (nPEP) is the provision of antiretroviral drugs to prevent HIV infection after unanticipated sexual or injection-drug–use exposure. The *U.S. Department of Health and Human Services (DHHS) Working Group on nPEP* made the following recommendations for the United States. For persons seeking care less than 72 hours after non-occupational exposure to blood, genital secretions, or other potentially infectious body fluids of a person known to be HIV infected, when that exposure represents a substantial risk for transmission, a 28-day course of highly active antiretroviral therapy (HAART) is recommended. Antiretroviral medications should be initiated as soon as possible after exposure. For persons seeking care more than 72 hours after non-occupational exposure to blood, genital secretions, or other potentially infectious body fluids of a person of unknown HIV status, when such exposure would represent a substantial risk for transmission if the source were HIV infected, no recommendations are made for the use of nPEP. Clinicians should evaluate risks and benefits of nPEP on a case-by-case basis. For persons with exposure histories that represent no substantial risk for HIV transmission or who seek care more than 72 hours after exposure, DHHS does not recommend the use of nPEP. Clinicians might consider prescribing nPEP for exposures conferring a serious risk for transmission, even if the person seeks care more than 72 hours after exposure if, in their judgment, the diminished potential benefit of nPEP outweighs the risks for transmission and adverse events. For all exposures, other health risks resulting from the exposure

should be considered and prophylaxis administered when indicated. Risk-reduction counseling and indicated intervention services should be provided to reduce the risk for recurrent exposures. Source: http://www.cdc.gov/mmwr/PDF/rr/rr5402.pdf

Note: nPEP is a risk reduction method option involving a medical referral that may be offered for a client's consideration as individually appropriate during *any* public health strategy or risk reduction activity and documented as an activity and referral for that session.

2015/2016 Prioritized Risk Group Definitions and Points of Consideration

Approved at the September 12, 2014 ILHPG Meeting

1. HIV positive and HIV negative Men Who Have Sex with Men (MSM):

A high-risk MSM is defined as:
• any male (including a transgender male) aged 12 years or older who has ever had anal sex with a male (including transgender male).
The following risk subgroup is also prioritized but solely for Risk Reduction Activities:
• A potentially high-risk MSM adolescent is defined as any male (including any transgender male), age 13-19 years, who reports ever having had oral sex with a male (including a transgender male) or who states he is sexually attracted to males (including transgender males).

2. HIV positive and HIV negative High Risk Heterosexuals (HRH):

A HRH is defined as:
A male (including a transgender male) not meeting MSM definitions or a Female (including transgender female)
(1) who do not meet IDU definition, and
(2) who disclose ever having vaginal or anal sex with someone of the other current gender and
(3) who also disclose meeting one of the criteria below:
• Male or Female living with HIV Disease
• Male or Female who has ever had vaginal or anal sex with an HIV positive partner of the other sex
• Female (including a transgender female) who self-report having a laboratory-confirmed STD in the past 12 months
• Female (including a transgender female) who ever had condomless anal sex with a male

3. HIV positive and HIV negative Injection Drug User (IDU):

A high-risk IDU is defined as a person of any gender who:
• does not meet the MSM definition, and
• discloses ever sharing injection equipment or supplies

4. HIV positive and HIV negative MSM/IDU:

A high risk HIV positive and HIV negative MSM/IDU is defined as any male or transgender male who meets the definitions of both MSM and IDU who discloses:
• ever having anal sex with a male or transgender male, and
• ever sharing injection equipment or supplies

5. HIV positive persons with "Other Risk"

An HIV positive person with Other Risk is defined as a person of any gender who:

- is not known to meet the MSM, IDU, HRH, or MSM/IDU definitions,
    - Never had anal sex with a Male in their lifetime
    - Never had vaginal sex with a Female in their lifetime
    - Never shared injection equipment in their lifetime

HIV positive persons disclosing no sexual or injection risk are not prioritized for Behavioral interventions to reduce sexual or injection risk until such a relevant risk disclosure is made. They are prioritized for all biomedical interventions intended to link or reengage them into HIV medical treatment and to strengthen their treatment adherence:

HIV positive persons with MSM, HRH, IDU, MSM/IDU or Other Risk are prioritized for **Surveillance-Based Services** if the person:

- has been reported to IDPH HIV Surveillance as confirmed HIV+ and
- meets one of the following criteria:
  i. HIV-diagnosed within the past 12 months OR
  ii. No CD4 or VL reported within the past 12 months OR
  iii. An STI Co-infection reported within the past 12 months

Other important points of consideration:

- **HIV positive individuals** falling within any of the risks identified above should be a top priority within each risk category.
- **Transgender individuals** may be included within any priority population based on *personal risk history* and *current gender identification.* Transgender identity does not mean an individual engages in risk behaviors. Gender reassignment surgery should not be assumed, and unless a transgender client *opts* to disclose an operative status, risk assessment should assess sexual risks inclusive of the possibilities for male and female anatomy. Transgender females are a high priority for HIV prevention services. The positivity rate among transgender women tested by all IDPH and DASA funded project throughout Illinois between 2008 and 2013 was 1.9%, falling between the HIV seropositivity rates for African American MSM (2.8%) and Latino MSM (1.8%).
- **Persons made vulnerable** by circumstances such as incarceration or domestic violence may be prioritized in any risk group when their individual risk and biomedical histories include prioritized risks defined above.
- **Young adults** with any of the risks identified above should be prioritized within each subpopulation category.

Strategies and Interventions for Risk-Targeted Grants

Key Public Health Strategies

	Hepatitis C testing (for IDUs and MSM/IDU)
Comprehensive Risk Counseling Services (CRCS)	**Internet Risk Reduction Counseling (IRRC)**
HIV Counseling, Testing and Referral (HCTR) with Linkage To Care (LTC)	**Partner Services (for CBOs)**
Harm Reduction/Syringe Exchange/Naloxone	**Partner Services (Health Departments)**
Hepatitis A & B Vaccination	**Surveillance-Based Services**
Human Papilloma Virus Vaccination	**Targeted Outreach STI Screening (gonorrhea, Chlamydia, syphilis)**

Comprehensive Risk Counseling Services (CRCS)

- CDC-approved Public Health Strategy in Risk Reduction Activity category
- Ideal for the highest at-risk clients having difficulty initiating or sustaining risk-reduction behaviors.
- One-on-one 45-minute in-depth counseling sessions that include risk assessment, risk reduction plan development, multiple referrals and behavior change measurement over time.
- Requires a specific training in this strategy
- *Approved targeted individuals: All prioritized populations (see pgs. 8-9).*

HIV Counseling, Testing and Referral (HCTR) and Linkage to Care (LTC)

- This strategy is cost-effective for risk populations with 1% rate of new HIV diagnosis.
- For Department requirements for this strategy, see pg 36. For detailed guidance, refer to the Department's recently updated HIV Prevention Counseling, Testing and Referral Guidance Manual.
- CDC-approved Public Health Strategy
- Available testing includes FDA approved and CLIA-waived rapid HIV testing and supplemental HIV testing for confirmatory HIV test results.
- Referrals are individually appropriate; clients are provided with assistance in making linkages; and referrals and linkages are tracked.
- Goal is to provide HIV testing, risk assessment and risk reduction counseling.
- Requires a specific training in this strategy (see HTCR Requirements starting on p36)
- Linkage to Care (LTC) and Partner Services (PS) *triggered by a testing session* are parts of HIV Counseling and Testing and require no separate scopes of service. HCT service units awarded to an applicant agency automatically include initiating LTC and PS for testing-identified PWHIV per IDPH HCT policy.
- *Approved targeted individuals:*
  For HCTR: All prioritized populations not previously diagnosed as HIV positive.
  For LTC: All individuals testing HIV positive.

Comprehensive Harm Reduction Services –

- This Key Public Health Strategy in the Risk Reduction Activity category includes the follow components. Provision of all three components is not required.
- **Harm Reduction Counseling**
  - One-on-one 15-20 minute counseling sessions with IDUs to help reduce their risk for HIV and discuss proper injection techniques, vein care, hepatitis screening, and substance abuse treatment referral.
  - Includes risk assessment and a risk reduction plan.
- **Syringe Exchange**
  - Prevention agencies should consider providing a Comprehensive Harm Reduction Services program including legal research-linked syringe exchange. A Federal ban prohibits the use of Federal funds for syringe exchange, however Illinois General Revenue Funds may be used to support syringe exchange.
- **Naloxone**
  - Participants in Syringe Exchange Programs (SEP) are trained by SEP providers in SKOOP (Skills and Knowledge on Opiate Overdose Prevention). Trained participants receive naloxone prescription/medication at the syringe exchange program (SEP) through a standing medical order by a medical doctor.
  - *Approved targeted individuals: HIV positive and negative high risk IDU and MSM/IDU of all ages, genders, races, ethnicities.*

Integrated Viral Hepatitis Prevention Strategies

- These CDC-approved strategies categorized as Risk Reduction Activities include:
  - Hepatitis A Vaccination
  - Hepatitis B Vaccination
  - Hepatitis C Testing
- The Department will provide HCV rapid test kits for projects approved to test IDUs.
- *Approved targeted individuals:*
  1. *For HAV & HBV vaccinations: all prioritized populations (See pgs. 8-9).*
  2. *For Hepatitis C testing: IDU and MSM/IDU populations only*

Human Papilloma Virus Vaccination

- This CDC-approved strategy is categorized as a Risk Reduction Activity.
- A complete series for either HPV4 or HPV2 consists of 3 doses. The second dose should be administered 4 to 8 weeks (minimum interval of 4 weeks) after the first dose; the third dose should be administered 24 weeks after the first dose and 16 weeks after the second dose (minimum interval of at least 12 weeks).
- *Approved Targeted Individuals:*
  - *For HPV: All prioritized populations (see pgs. 8-9) falling within the age, gender and serostatus criteria listed below.*
    - HPV4 for Men who have sex with men through age 26 years who have received no or incomplete doses
    - Immunocompromised (including HIV infected) persons through age 26 years who have received no or incomplete doses
    - HPV vaccines are not recommended for use in pregnant women. However, pregnancy testing is not needed before vaccination. If a woman is found to be

pregnant after initiating the vaccination series, no intervention is needed; the remainder of the 3-dose series should be delayed until completion of pregnancy

Internet Risk Reduction Counseling

- This Risk Reduction Activity strategy consists of health educators conducting one-on-one risk reduction counseling sessions with high-risk individuals in Internet chat rooms or mobile aps, such as Grinder, etc.
- Providers are encouraged to refer on-line clients to more intensive services such as HIV Counseling and Testing and/or Effective Behavioral Interventions.
- A separate IRRC training is required for a health educator to become certified
- *Approved targeted individuals: All prioritized populations (see pgs. 8-9).*

Partner Services – for Health Departments and CBOs

- For Department requirements for this strategy, see pg 36.
- Partner Services (PS) involves working with newly and ongoing diagnosed HIV+ clients to elicit and then notify sex and needle sharing partners regarding their exposure to HIV and other STIs, if applicable.
- Partners of the Index Patient are offered HIV counseling and testing and linkage to Care services if a either a positive diagnosis is made for the partner or a prior positive diagnosis is reported by the partner.
- Partner Elicitation Interviewing ***triggered by a testing session*** is part of HIV Counseling and Testing and requires no separate scopes of service. HCT service units awarded to an applicant agency automatically include initiating PS for testing-identified PWHIV per IDPH HCT policy.
- Specific roles are designated for Health Departments and Community Based Organizations (Non-Health Department Agencies).
- *Health Departments* may provide all steps of elicitation and notification associated with providing Partner Services including cases identified through Surveillance records.
- *Community Based Organizations (CBOs)* shall provide services up to and including partner elicitation, but shall not provide direct notification services, unless officially designated by the Illinois Department of Public Health. Community Based organizations do have the authority to be present during a dual notification as requested by the index patient; however, unless officially designated by the Illinois Department of Public Health, the community based organization's role does not include direct notification of partners of positives identified through testing nor identification and direct notification of partners of positives reported through Surveillance records.
- *Approved targeted individuals: Confirmed HIV positive clients and their sex and/or injection partners.*

Targeted Outreach STI Screening (gonorrhea, Chlamydia, syphilis)

- CDC-approved Public Health Strategy
- Risk-targeted outreach STI screening (e.g., gonorrhea, Chlamydia, and syphilis) for persons with prioritized HIV risk histories
- IDPH provides approved collection devices for urine and venous blood specimens.
- *Approved targeted individuals: All prioritized populations.*

Surveillance-Based Services (SBS)

- In this strategy, the Department refers case information to Local Health Departments (LHDs) or Designated Community Based Organizations about confirmed HIV+ persons reported to IDPH HIV Surveillance who meet one of the following criteria:
  - **HIV-diagnosed within the past 12 months OR**
  - **No CD4 or VL reported within the past 12 months OR**
  - **An STI Co-infection reported within the past 12 months**
- SBS begins with an individual assessment of risk and service needs including HIV Status Awareness, Linkage or re-engagement to HIV and/or STI treatment, Partner Services, and Risk Reduction Counseling or individual level effective behavioral intervention.
- *Approved targeted individuals: HIV positive persons meeting the above criteria referred by the Department to approved SBS providers.*

Behavioral and Biomedical Interventions:

ARTAS[1]	**Project AIM**[2]
CLEAR-for PWHIV[1]**, for H.R. Negatives**[2]	**Project START-for PWH**[1]**, for HR negatives**[1]
Community PROMISE[1]	**RAPP**[2]
CONNECT-for Serodiscordant[1]**, for others**[2]	**Respect-Two Session Format**[2]
Cuidate! [2]	**Risk Reduction Counseling (RRC)**[4]
d-up: Defend Yourself! [1]	**Safe in the City**[1]
Focus on Youth (FOY) with ImPACT[2]	**Safety Counts**[2]
Group Prevention & Support (GPS) [4]	**Shield**[2]
Healthy Love[2]	**SIHLE**[2]
Healthy Relationships[1]	**SISTA**[2]
Holistic Health Recovery Program (HHRP) [2]	**SISTA – Adaptation for Latinas**[2]
Many Men, Many Voices (3MV) [1]	**Sister to Sister**[1]
Medication Adherence[1]	**Street Smart**[2]
Modelo de intervencion Psicomedia (MIP) [2]	**Together Learning Choices**[2]
Mpowerment[1]	**TWISTA**[1]
NIA[2]	**VIBES**[3]
Personal Cognitive Counseling (PCC) [1]	**VOICES/VOCES-for MSM**[1]**, for HRH**[2]
Platicas de Comadres[1]	**WILLOW**[1]
Popular Opinion Leader (POL) [1]	

[1] CDC Supported Effective Behavioral Interventions–proven Effective *and* Cost-Effective
[2] CDC Unsupported Effective Behavioral Interventions – proven Effective but *not* Cost-Effective
[3] Locally Developed Intervention with Evidence of Effective- some evidence for Effectiveness, but not Cost-Effectiveness
[4] Unvetted Intervention– not proven Effective or Cost-Effective

Interventions are services provided to people in an effort to decrease their risk of acquiring or transmitting HIV. The US Centers for Disease Control and Prevention (CDC) has identified interventions that research has shown to be *effective*, that is, reducing risk behavior, and others that meet its raised standard of *cost-effectiveness*, that is, preventing enough infections per dollar invested to justify public funds investment. Grant Monitors and Lead Agencies should prioritize funding providers already prepared to conduct cost-effective interventions for a prioritized population in a given area whenever possible. When this is not immediately possible, Grant Monitors and Lead Agencies should next prioritize funding providers already prepared to conduct Effective Behavioral Interventions which are not cost-effective, then as a third priority Locally Developed Intervention with Evidence of Effective, and finally, only if no better option is available, Unvetted Interventions. However, providers funded for anything less than CDC-vetted Effective Behavioral Interventions shall be required to have one or more staff complete training during the project period for a cost-effective CDC Supported Effective Behavioral Intervention if any are appropriate for the target population, funding and circumstances and if not then the best CDC-vetted Effective Behavioral Interventions appropriate for the target population, funding and circumstances. Unvetted interventions must be documented as named, confidential intervention with verified names and birthdates included for future evaluation. For additional guidance on implementing Unvetted Interventions, see page 47.

CLEAR

- This intervention is effective and cost-effective for PWHIV.
- This intervention is effective for high risk HIV-negative persons, but CDC-unsupported due to weak cost-effectiveness for this population.
- CLEAR is a health promotion intervention for men and women 16 and older living with HIV and high-risk HIV-negative individuals.
- CLEAR is a client-centered intervention delivered one-on-one using cognitive behavioral techniques to change behaviors. CLEAR can be effectively integrated into a program's CRCS activities.
- Requires a separate training for certification.
- *Approved targeted individuals: HIV positive and negative high risk MSM, HRH, IDU, and MSM/IDU ages 16 and older, of all ages, genders, races and ethnicities.*

Community PROMISE

- This intervention is effective and cost-effective for all prioritized risk populations.
- Peers Reaching Out and Modeling Intervention Strategies (PROMISE)
- An effective, community-level intervention that relies on role model stories and peer advocates from the community
- A community identification process obtains role model stories from individuals of target populations who have made positive behavior change.
- Requires a separate training for certification.
- *Approved targeted individuals: HIV positive and negative high risk MSM, HRH, IDU, and MSM/IDU of all ages, genders, races and ethnicities.*

CONNECT

- This intervention is effective and cost-effective for HIV-serodiscordant heterosexual couples.
- CONNECT is a six-session, relationship-based intervention that teaches heterosexual couples techniques and skills to enhance the quality of their relationship, communication, and shared commitment to safer behaviors.
- CONNECT integrates techniques commonly used in family therapy to allow couples to work together to solve shared problems.
- CONNECT targets heterosexual women and men ages 18 and over and their main sexual partners.
- The intervention requires training for certification.
- *Approved targeted individuals: HIV positive and negative high risk HRH (male and female) ages 18 and older of all races and ethnicities, and their partners.*

Cuidate!

- This intervention is effective, but CDC-unsupported due to weak cost-effectiveness.
- !Cuídate!, which means "take care of yourself," is a culturally-based, group-level intervention to reduce HIV sexual risk behavior among Latino youth.
- It is based on Social Cognitive Theory, Theory of Reasoned Action, and Theory of Planned Behavior, and incorporates cultural beliefs that are common among Latino subgroups and associated with sexual risk behavior.
- Can be lengthy and labor-intensive

- For more information, please visit the ¡Cuídate! Homepage at http://www.effectiveinterventions.org/en/WhatsNew.aspx
- *Approved targeted individuals: HIV positive and negative high risk Hispanic MSM and HRH (male and female) ages 13-24.*

d-up: Defend Yourself!

- This intervention is CDC-supported due to its effectiveness and cost-effectiveness.
- d-up! is a cultural adaptation of the Popular Opinion Leader (POL) intervention and is designed to change social norms and perceptions of black MSM regarding condom use.
- d-up! specifically targets black MSM who are in social networks with other black MSM. Opinion leaders change risky sexual norms in these networks.
- Requires a separate training for certification.
- *Approved targeted individuals: HIV positive and negative high risk black MSM of all ages.*

Focus on Youth (FOY) with ImPACT

- This intervention is effective, but CDC-unsupported due to weak cost-effectiveness.
- Intervention is an eight-session community-based program that provides youth with the skills and knowledge they need to protect themselves from HIV and STDs.
- The curriculum utilizes fun, interactive activities such as games, role plays and discussions to convey prevention knowledge and skills.
- The eight sessions are accompanied by Informed Parents and Children Together (ImPact), a 90-minute one-on-one parental intervention.
- Requires separate training for certification.
- *Approved targeted individuals: HIV negative high risk black MSM ages 13-24 and high risk black HRH (male and female) ages 12-15.*

Group Prevention and Support (GPS)

- This locally-developed intervention is non-standardized and unvetted for effectiveness.
- Unvetted interventions may be funded only when no cost-effective, effective or locally developed intervention with evidence of effectiveness is logistically possible, and then only if the grant or subgrant agreement specifies that the provider will train staff during the project period in a CDC-evaluated cost-effective or effective intervention.
- Agencies must submit with their grant application a copy of the intended curriculum with measurable outcome objectives and pre- and post-test instruments to measure participants' progress toward the defined outcome objectives.
- Sessions should be conducted with small groups (5-12) of prioritized risk clients
- Skills-building Session objectives for PLWH may include:
  - Medical care first-time linkage, retention and reengagement
  - Medication adherence
  - Partner safety
  - HIV-status disclosure
- Session objectives for prioritized risk clients of any serostatus may include:
  - HIV/STD Risk personalization
  - Personal health goal-setting and risk reduction plan development

    - Behavioral risk reduction strategy skills appropriate to the group's risk and serostatus
    - Biomedical risk reduction strategies appropriate to the group's risk and serostatus
- This Unvetted Intervention must be documented as named, confidential intervention with verified names and birthdates included for future evaluation.
- *Approved targeted individuals: All prioritized populations (see pgs. 8-9).*

Healthy Love

- This intervention is effective, but CDC-unsupported due to weak cost-effectiveness.
- *Healthy Love* is a single session, evidence-based, safer sex intervention developed for African American women. It is delivered to small groups of women that share a social connection (e.g., friends, sororities, neighborhoods, etc.) in settings of their choosing.
- The goals of *Healthy Love* are to reduce unprotected sex with male partners and the number of sex partners and to increase sexual abstinence, consistent use of condoms and other protective barriers, and the number of women who get tested for HIV and receive their test results. The intervention achieves these goals by increasing participants' HIV and STD knowledge, positive attitudes towards sex/sexuality, risk perception, condom use/negotiation skills, and self-efficacy to increase safer sex or protective behaviors for HIV and STD prevention.
- The *Healthy Love* intervention is a 3-4 hour session that consists of 12 activities that comprise three intervention categories: Setting the Tone, The Facts, and Safer Sex. Two culturally competent female facilitators deliver the intervention to groups of women ranging from 5-14 participants in an informal setting of the group's choosing that provides a confidential and conducive learning environment. *Healthy Love* provides participants with HIV/STD-related facts, a personalized risk assessment, condom negotiation techniques, and multiple condom use skills-building activities delivered in a fun, sex-positive environment. The intervention activities include discussions, demonstrations, role plays, and skills-building opportunities. Safer sex kits (containing condoms, dental dams, personal lubricants and educational materials) as well as an optional HIV testing opportunity are provided to participants at the end of the interactive session.
- *Healthy Love* is based on the Health Belief Model and Social Cognitive Theory.
- *Approved targeted individuals: The intervention specifically targets HIV positive and negative African American women, 18 years of age and older, who are not pregnant or intending to become pregnant in the next 6 months. Even though Healthy Love was only tested with African American women, the intervention also may be tailored for women of other races/ethnicities and groups of women with mixed ethnicities.*

Healthy Relationships

- This intervention is rated effective and cost-effective.
- The intervention is a five-session small group program for men and women living with HIV.
- Decision-making and problem-solving skills are developed to enable participants to make informed and safe decisions about disclosure and behavior.
- Role plays, movie clips are utilized in group work.
- Requires separate training for certification.

- *Approved targeted individuals: HIV positive high risk MSM, HRH, IDU, and MSM/IDU ages 18 and older of all genders, races and ethnicities.*

Holistic Health Recovery Program (HHRP)

- This intervention is effective, but CDC-unsupported due to weak cost-effectiveness.
- HHRP is a 12-session group level program for HIV+ and HIV- injection drug users.
- Through skills-building exercises, the intervention aims to reduce risky sex and drug use behaviors and improve the quality of life.
- Requires separate training for certification.
- *Approved targeted individuals: HIV positive and negative high risk IDU and MSM/IDU of all ages, genders, races and ethnicities.*

Many Men, Many Voices (3MV)

- This intervention is CDC-supported due to its effectiveness and cost-effectiveness.
- A seven-session group-level intervention to prevent HIV and STDs among adult black men who have sex with men (MSM).
- The intervention addresses culture, social and religious norms, sexual relationship dynamics and other topics.
- Requires a separate training for certification.
- *Approved targeted individuals: HIV negative high risk black MSM ages 18 and older.*

Modelo de intervencion Psichomedica (MIP)

- This intervention is effective, but CDC-unsupported due to weak cost-effectiveness.
- MIP is an HIV psycho-medical intervention for injection drug users (IDUs) based on motivational interviewing, cognitive behavioral theories, and case management.
- MIP offers seven one-on-one counseling sessions over a 3-6 month period, with motivational interviewing used to increase clients' motivation to assess the benefits of changing their drug and sex-related HIV risk behaviors and to develop a plan to facilitate behavior change.
- Requires a separate training for certification.
- *Approved targeted individuals: HIV positive and negative high risk IDU of all genders, races and ethnicities.*

Mpowerment

- This intervention is CDC-supported due to its effectiveness and cost-effectiveness.
- A community-level intervention designed for young MSM, ages 18-29.
- The intervention is run by young MSM from the community and is based at an Mpowerment "drop-in center".
- The intervention includes small and large community events, safer sex group discussions, a media campaign, and peer-led community outreach.
- Requires a separate training for certification.
- *Approved targeted individuals: HIV positive and negative high risk MSM ages 18-29.*

NIA

- This intervention is effective, but CDC-unsupported due to weak cost-effectiveness.

- Nia is a six-hour, two to four-session, video-based small group level intervention to educate African-American men about HIV and its effect on their community, bring groups of men together, increase motivation to reduce risks, and help men learn new skills to protect themselves and others by promoting condom use.
- The target population for Nia is African-American men (18 and over) who have sex with women.
- Nia requires training for certification.
- *Approved targeted individuals: HIV positive and negative black male HRH ages 18 and older.*

Personal Cognitive Counseling (PCC)

- This intervention is CDC-supported due to its effectiveness and cost-effectiveness.
- PCC is an individual-level, single session counseling intervention designed to reduce high risk sexual behaviors among men who have sex with men (MSM) who are repeat testers for HIV
- Requires a separate training for certification.
- For more information, please visit the Personalized Cognitive Counseling homepage at http://www.effectiveinterventions.org/en/WhatsNew.aspx
- *Approved targeted individuals: HIV negative high risk MSM of all ages, races, and ethnicities.*

Platicas de Comadres

- This intervention is effective, but CDC-unsupported due to weak cost-effectiveness.
- An HIV prevention intervention for Hispanic HRH females that uses storytelling to illustrate behavior change.
- Translates to "chats between female friends."
- Latina outreach workers have HIV prevention discussions with other females at places of business in their communities such as beauty parlors.
- *Approved targeted individuals: HIV positive and negative high risk Hispanic HRH females of all ages.*

Popular Opinion Leader (POL)

- This intervention is CDC-supported for MSM including MSM/IDU due to its effectiveness and cost-effectiveness.
- This intervention is effective, but CDC-unsupported for HRH and IDU due to weak cost-effectiveness.
- Involves identifying and training "popular opinion leaders" to provide HIV prevention messages and support to peers in specific social networks.
- Goal is to change community norms about HIV prevention.
- Requires separate training for certification.
- *Approved targeted individuals: HIV positive and negative MSM, HRH, IDU, and MSM/IDU of all ages, genders, races and ethnicities.*

Project AIM

- This intervention is effective, but CDC-unsupported due to weak cost-effectiveness.

- A group-level youth development intervention designed to reduce HIV risk behaviors among youth.
- Consists of 12 sessions divided into 4 parts. Project AIM uses group discussions, interactive and small group activities, and role-plays to encourage youth to explore their personal interests, social surrounding, and what they want to become as an adult.
- AIM targets at-risk youth, ages 11 to 14.
- *Approved targeted individuals: HIV positive and negative high risk HRH (male and female) ages 11 - 14 of all races and ethnicities.*

Project START

- This intervention is CDC-supported only as adapted for HIV+ Persons due to its effectiveness and cost-effectiveness.
- This intervention is effective but CDC-unsupported for HIV-negative incarcerated persons, due to weak cost-effectiveness.
- Project START is a multi-session intervention for people being released from a correctional facility and returning to the community. Two sessions are provided with the client before release and four sessions after release.
- The intervention is based on the framework of incremental risk reduction and focuses on increasing clients' awareness of their sexual and drug use risk behaviors after release and providing them with tools and resources to reduce their risk.
- The intervention requires training for certification.
- *Approved targeted individuals: HIV positive and negative high risk MSM, HRH, IDU, and MSM/IDU of all ages, genders, races and ethnicities being released from a correctional facility.*

RAPP: Real AIDS Prevention Project

- This intervention is effective, but CDC-unsupported due to weak cost-effectiveness.
- A community-level intervention designed to increase consistent condom use by high-risk women and their partners and to make safer sex a community norm.
- Uses peer networks for community outreach.
- Uses role model stories, small group activities, and one-on-one counseling
- Requires separate training for certification.
- *Approved targeted individuals: HIV positive and negative high risk female HRH of all ages.*

Respect

- This intervention is ***effective*** for heterosexuals in its original ***two session*** protocol, but ***ineffective*** in its ***one*** session adaptation. The two session version has not been CDC-evaluated as a stand-alone intervention apart from HIV Counseling and Testing.
- RESPECT is an individual-level, client-focused HIV prevention counseling intervention consisting of two brief, interactive counseling sessions.
- RESPECT can be implemented for any population at increased risk for HIV/STDs.
- Utilizes a "teachable moment" to motivate clients to change risk-taking behaviors

- Requires separate training for certification.
- *Approved targeted individuals: HIV positive and negative HRH of all ages, genders, races and ethnicities.*

Risk Reduction Counseling

- This intervention is non-standardized and unvetted for effectiveness. Unvetted interventions may be funded only when no cost-effective, effective or locally developed intervention with evidence of effectiveness is logistically possible, and then only if the grant or subgrant agreement specifies that the provider will train staff during the project period in a CDC-evaluated cost-effective or effective intervention.
- A one-on-one, 15-20 minute counseling session with an at-risk client that includes a risk assessment and the client identifying :a behavior they have engaged in through which they could transmit or acquire HIV, facilitators and inhibitors of this risk behavior, a safer behavior goal, action steps to reduce risk for HIV, and referrals to support risk reduction.
- Can be a one-time session
- Risk Reduction counseling is distinct from HIV Test. Counseling conducted for HIV testing is documented as "HIV Counseling and Testing" and not as Risk Reduction Counseling.
- This Unvetted Intervention must be documented as named, confidential intervention with verified names and birthdates included for future evaluation.
- *Approved targeted individuals: HIV positive and negative high risk MSM, HRH, IDU, and MSM/IDU of all ages, genders, races and ethnicities.*

Safe in the City

- This intervention is CDC-supported due to its effectiveness and cost-effectiveness.
- A 23-minute HIV/STD prevention video for STD clinic waiting rooms that has been shown to be effective in reducing STDs among racially diverse groups of STD clinic patients.
- Safe in the City aims to increase condom use and other safe sex behaviors among HRH and MSM populations of varying races.
- *Approved targeted individuals: HIV positive and negative high risk MSM, HRH, of all ages, genders, races and ethnicities.*

Safety Counts

- This intervention is effective, but CDC-unsupported due to weak cost-effectiveness.
- An intervention designed for out-of-treatment active injection and non-injection drug users aimed at reducing both high-risk drug use practices and sexual behaviors.
- Intervention includes a total of seven sessions: two group sessions, one individual counseling session, two social events, and two follow-up contacts (these can be phone contacts)
- Requires separate training for certification.

- *Approved targeted individuals: HIV positive and negative high risk IDU of all ages, genders, races and ethnicities.*

SHIELD: Self-Help in Eliminating Life Threatening Diseases

- This intervention is effective, but CDC-unsupported due to weak cost-effectiveness.
- SHIELD is a six-session, group-level intervention that trains current and former drug users to be peer educators who share HIV prevention information with people in their social networks.
- Peer educators lead small groups (4-12 participants) through problem-solving activities, role-plays, and demonstrations.
- The target populations for SHIELD are male and female adults (18 and over) who are current or former "hard" drug users (heroin, cocaine, crack) who interact with other drug users. Requires training for certification.
- *Approved targeted individuals: HIV positive and negative male and female high risk MSM, HRH IDU, and MSM/IDU of all races and ethnicities who are current and former drug users.*

SIHLE

- This intervention is effective, but CDC-unsupported due to weak cost-effectiveness.
- SIHLE is an adaptation of SISTA and is a peer-led, social-skills training intervention aimed at reducing HIV sexual risk behavior among sexually active, African-American teenage females, ages 14-18.
- SIHLE consists of four three-hour small-group (10-12 girls) sessions (group discussions, lectures, role-plays) delivered by two peer facilitators (ages 18-21) and one adult facilitator in a community-based setting.
- SIHLE requires training for certification.
- The American Psychological Association Latina Adaptation Guide for SISTA may be used as a reference tool for adapting SIHLE for Latina adolescents.
- *Approved targeted individuals: HIV positive and negative <u>black</u> high risk HRH females ages 14-18. The intervention may be adapted to target HIV positive and negative <u>Hispanic</u> high risk HRH females ages 14-18.*

SISTA and SISTA adaptation for Latinas

- This intervention is effective, but CDC-unsupported due to weak cost-effectiveness.
- A group prevention behavioral intervention for sexually active, high-risk heterosexual African-American females
- SISTA is delivered in five two-hour sessions (and two other optional sessions) that emphasize gender and ethnic pride
- Requires a separate training for certification.
- *Approved targeted individuals: HIV positive and negative black high risk HRH (female) ages 18 and above. The intervention may be adapted to target HIV positive and negative <u>Hispanic</u> high risk HRH (female) ages 18 and above.*

Sister to Sister

- This intervention is CDC-supported due to its effectiveness and cost-effectiveness.
- Sister to Sister is a brief (20-minute) one-on-one, skills-based HIV/STD risk-reduction behavioral intervention for sexually active African-American women 18 to 45 years old that is delivered during the course of a routine medical visit.
- The intervention is highly structured must be implemented in a *primary health care setting* by nurses, health educators or other professional clinical staff using videos, brainstorming, experiential exercises, and skills-building activities.
- Sister to Sister requires training for certification.
- *Approved targeted individuals: HIV positive and negative sexually active black high risk HRH (female) ages 18 -45.*

Street Smart

- This intervention is effective, but CDC-unsupported due to weak cost-effectiveness.
- An HIV/STD prevention intervention for runaway and homeless youth, or disenfranchised youth
- The program consists of eight two-hour group sessions, one individual counseling session and one visit to a healthcare agency.
- Program members participate in role plays, activities, and video production.
- Requires separate training for certification.
- *Approved targeted individuals: HIV positive and negative high risk HRH females and males ages 13-24 of all races and ethnicities.*

Together Learning Choices

- This intervention is effective, but CDC-unsupported due to weak cost-effectiveness.
- TLC targets young people, aged 13-29, living with HIV.
- Through highly participatory, interactive small group work, participants identify ways to increase use of health care, decrease risky sexual and drug/alcohol use behaviors, and improve quality of life.
- Requires a separate training for certification.
- *Approved targeted individuals: HIV positive high risk MSM, HRH, IDU, MSM/IDU, and transgender individuals ages 13-29 of all genders, races and ethnicities.*

TWISTA

- TWISTA is an adaptation of the effective behavioral group-level intervention SISTA modified for high-risk African-American transgender MTF.
- TWISTA is delivered in five two-hour sessions emphasizing transgender and ethnic pride.
- Requires a separate training for certification.
- *Approved targeted individuals: HIV positive and negative <u>black</u> high risk transgender MTF ages 18 and above.*

VIBES

- This intervention is locally developed with some evidence of effectiveness, but is unvetted for cost-effectiveness.

- A group HIV prevention behavioral intervention for African-American Young Men Who Have Sex with Men (YMSM)
- VIBES is delivered in six two-hour sessions that emphasize skills-building and cultural empowerment
- Requires a separate training for certification.
- *Approved targeted individuals: HIV positive and negative black high risk MSM ages 13-19.*

VOICES/VOCES

- This intervention *when used with MSM* is CDC-supported due to its effectiveness and cost-effectiveness. This intervention *when used with HRH* is effective, but CDC-unsupported due to weak cost-effectiveness.
- Video Opportunities for Innovative Condom Education and Safer Sex – Requires training for certification
- An STD-clinic based group prevention intervention for African-American and Latino HRH men and women and MSM.
- The intervention is delivered in one 45-minute session with gender-specific groups of 4-8 clinic patients by playing a video and beginning a condom discussion/distributing condoms.
- *Approved targeted individuals: HIV positive and negative black and Hispanic high risk HRH (male and female) and MSM ages 18 and above.*

WILLOW

- This intervention is CDC-supported due to its effectiveness and cost-effectiveness.
- WILLOW is a social-skills building and educational intervention for adult heterosexual women 18-50 years old of any race living with HIV.
- An adaptation of the SISTA intervention, emphasizing gender pride, WILLOW consists of 4 four-hour small group sessions delivered by two trained adult female facilitators, one of whom is a woman living with HIV.
- Peer led intervention for women who are HIV positive led by women who are HIV positive
- WILLOW requires training for certification.
- *Approved targeted individuals: HIV positive female high risk HRH ages 18 -50.*

<u>Biomedical Strategies</u>

Medication Adherence

- This intervention is CDC-supported due to its effectiveness and cost-effectiveness.
- Adherence to anti-retroviral therapy (ART) is critical to the success of HIV treatment and treatment as prevention. However, the benefits of ART can be realized only by those individuals who are tested, diagnosed, timely linked to medical care, and start and adhere to ART to achieve viral suppression. In April 2011, eight individual and group-level evidence-based interventions to support HIV medication adherence were reviewed and

identified as "good-evidence" by the Centers for Disease Control & Prevention (CDC) Prevention Research Synthesis Project. The Capacity Building Branch selected four of the eight medication adherence interventions to be translated into an e-learning training toolkit for clinical and non-clinical HIV providers who serve persons living with HIV (PLWH). A fifth intervention, Pager messaging, was selected to be updated to a mobile application. These adherence interventions showed efficacy in improving either medication adherence and/or viral load among either ART naïve or ART experienced patients. - See more at: http://www.effectiveinterventions.org/en/HighImpactPrevention/BiomedicalInterventions/MedicationAdherence.aspx#sthash.BQcQqQ4t.dpuf

- *Approved targeted individuals: All HIV positive diagnosed individuals.*

ARTAS

- Anti-Retroviral Treatment and Access to Services (ARTAS) is an individual-level, multi-session, time-limited intervention delivered by HIV Case Managers to link individuals who have been recently diagnosed with HIV to medical care.
- ARTAS consists of up to five client sessions conducted over a 90 day period or until the client links to medical care – whichever comes first. Eligible clients should be within 6–12 months of receiving an HIV-positive diagnosis.
- During the client sessions, the Linkage Coordinator builds a relationship with the client. The client, focusing on his/her self-identified strengths, creates an action plan (known as the ARTAS Session Plan) with specific goals, including linking to medical care. Not every client will move sequentially through the five sessions nor will every client complete all five sessions.
- *Approved targeted individuals: Individuals who received an HIV positive diagnosis within the last 12 months.*

Note: For prevention providers, PrEP and nPEP are risk reduction *method* options involving a medical referral that may be offered for a client's consideration as individually appropriate during *any* public health strategy or risk reduction activity and documented as an activity and referral for that session.

Targeted High Risk Populations and Approved Interventions

MSM - Men Who Have Sex with Men

Population Definition: HIV positive and HIV negative Men Who Have Sex with Men (MSM)

A high-risk MSM is defined as:

• any male (including a transgender male) aged 12 years or older who has ever had anal sex with a male (including a transgender male).

The following risk subgroup is also prioritized but solely for Risk Reduction Activities:

• A potentially high-risk MSM adolescent is defined as any male (including any transgender male), age 13-19 years, who reports ever having had oral sex with a male (including a transgender male) or who states he is sexually attracted to males (including transgender males).

Note: **Transgender individuals** may be included within any priority population based on *personal risk history* and *current gender identification*. Gender reassignment surgery should not be assumed, and unless a transgender client opts to disclose an operative status, risk assessment should assess sexual risks inclusive of the possibilities for male and female anatomy. Transgender identity does not mean an individual engages in risk behaviors. Although Transgender identity is not considered a behavior risk priority population in and of itself, a specific section of interventions is included to guide service providers toward effective programming.

Key Public Health Strategies

ARTAS	Internet Risk Reduction Counseling (IRRC)
Comprehensive Risk Counseling Services	Partner Services (for CBOs)
HIV Counseling, Testing and Referral (HCTR) and Linkage to Care (LC)	Partner Services (Health Departments)
Hepatitis A & B Vaccination	STI Screening (gonorrhea, Chlamydia, syphilis)
Human Papilloma Virus Vaccination	

CDC-Supported Interventions

CLEAR (only for PWHIV)
Community PROMISE
d-up: Defend Yourself!
Healthy Relationships (only for PWHIV)
Many Men, Many Voices (3MV)
Medication Adherence (only for PLWH)
Mpowerment
Personal Cognitive Counseling (PCC) with HCT
Popular Opinion Leader (POL)
Project Start (only for PLWH)

CDC-Unsupported Interventions

Cuídate!
Focus on Youth (FOY) with ImPACT
Project Start for HIV-negatives
SHIELD
Street Smart
Together Learning Choices

Locally Developed Intervention with Evidence of Effective

VIBES

Unvetted Interventions

Group Prevention & Support (GPS)
Risk Reduction Counseling (RRC)

IMPORTANT: *Please be sure to read the description of interventions listed at the back of this document thoroughly! The risks, ages, races and serostatus allowed for each intervention will be listed directly in the description.*

HRH - High Risk Heterosexual

Population Definition: HIV positive and HIV negative High Risk Heterosexuals (HRH)

A High Risk Heterosexual (HRH) is defined as:

A male (including a transgender male) not meeting MSM definitions and a female (including a transgender female)

(1) who does not meet IDU definition, and

(2) who discloses ever having vaginal or anal sex with someone of the other current gender and

(3) who also discloses meeting ***one*** of the criteria below:

- Male or Female living with HIV Disease
- Male or Female who has ever had vaginal or anal sex with an HIV positive partner of the other sex
- Female (including a transgender female) who self-reports having a laboratory-confirmed STD in the past 12 months
- Female (including a transgender female) who has ever had condomless anal sex with a male

Note: **Transgender individuals** may be included within any priority population based on personal risk history and current gender identification. Gender reassignment surgery should not be assumed, and unless a transgender client opts to disclose an operative status, risk assessment should assess sexual risks inclusive of the possibilities for male and female anatomy. Transgender identity does not mean an individual engages in risk behaviors. Although Transgender identity is not considered a behavior risk priority population in and of itself, a specific section of interventions is included to guide service providers toward effective programming.

Key Public Health Strategies

ARTAS	Internet Risk Reduction Counseling (IRRC)
Comprehensive Risk Counseling Services	Partner Services (for CBOs)
HIV Counseling, Testing and Referral (HCTR) and Linkage to Care (LC)	Partner Services (Health Departments)
Hepatitis A & B Vaccination	STI Screening (gonorrhea, Chlamydia, syphilis)
Human Papilloma Virus Vaccination	

CDC-Supported Interventions

CLEAR (HIV+ only)	Project Start (HIV+ only)
Community PROMISE	Safe in the City
CONNECT (Serodiscordant couples)	Sister to Sister
Healthy Relationships (HIV+ only)	TWISTA (for TransWomen)
Medication Adherence (HIV+ only)	WILLOW (HIV+ only)

CDC-Unsupported Interventions

Cuídate!
Focus on Youth (FOY) with ImPACT
NIA
RAPP
Healthy Love
Popular Opinion Leader
Project AIM
SIHLE
SHIELD
Platicas de Comadres
Respect (2 session)
SISTA
SISTA - adapted for Latinas
Street Smart
Together Learning Choices
VOICES/VOCES

Locally Developed Intervention with Evidence of Effective

None

Unvetted Interventions

Group Prevention & Support (GPS)
Risk Reduction Counseling (RRC)

IMPORTANT: *Please be sure to read the description of interventions listed at the back of this document thoroughly. The risks, ages, races and serostatus allowed for each intervention will be listed directly in the description.*

IDU – Injection Drug Users

Population Definition: HIV positive and HIV negative high risk Injection Drug Users

A high-risk injection drug user (IDU) is defined as a person of any gender who:

- does not meet the MSM definition and
- discloses ever sharing injection equipment or supplies

Note: **Transgender individuals** may be included within any priority population based on *personal risk history* and *current gender identification*. Gender reassignment surgery should not be assumed, and unless a transgender client opts to disclose an operative status, risk assessment should assess sexual risks inclusive of the possibilities for male and female anatomy. Transgender identity does not mean an individual engages in risk behaviors. Although Transgender identity is not considered a behavior risk priority population in and of itself, a specific section of interventions is included to guide service providers toward effective programming.

Key Public Health Strategies

ARTAS	Hepatitis C Testing
Comprehensive Risk Counseling Services	Harm Reduction/Syringe Exchange/Naloxone
HIV Counseling, Testing and Referral (HCTR) and Linkage to Care (LC)	Internet Risk Reduction Counseling (IRRC)
Group Prevention & Support (GPS)	Partner Services (for CBOs)
Hepatitis A & B Vaccination;	Partner Services (Health Departments)
Human Papilloma Virus Vaccination	Risk Reduction Counseling (RRC)

CDC-Supported Interventions

CLEAR (HIV+)
Community PROMISE
Healthy Relationships (HIV+)
Medication Adherence (HIV+)
Project START (HIV+)
Together Learning Choices
WILLOW

CDC-Unsupported Interventions

Modelo de Intervencion Psichomedica
Popular Opinion Leader (POL)
Project START (for HIV-negatives)
Respect (two session protocol)
Safety Counts
SHIELD

Locally Developed Intervention with Evidence of Effective

None

Unvetted Interventions

Group Prevention & Support (GPS)
Risk Reduction Counseling (RRC)

IMPORTANT**:** *Please be sure to read the description of interventions listed at the back of this document thoroughly. The risks, ages, races and serostatus allowed for each intervention will be listed directly in the description.*

MSM/IDU – Men Who Have Sex with Men Who Use Injection Drugs

Population Definition: A high risk HIV positive and HIV negative MSM/IDU is defined as any male (including a transgender male) who meets the definitions of both MSM and IDU who discloses:

• ever having anal sex with a male or transgender male, and
• ever sharing injection equipment or supplies

Note: **Transgender individuals** may be included within any priority population based on *personal risk history* and *current gender identification*. Gender reassignment surgery should not be assumed, and unless a transgender client opts to disclose an operative status, risk assessment should assess sexual risks inclusive of the possibilities for male and female anatomy. Transgender identity does not mean an individual engages in risk behaviors. Although Transgender identity is not considered a behavior risk priority population in and of itself, a specific section of interventions is included to guide service providers toward effective programming.

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Hepatitis A & B Vaccination	Partner Services (Health Departments)

CDC-Supported Interventions

All Public Health strategies and interventions approved for MSM or IDU populations are approved for MSM/IDU. See pages 4 and 6 for specific interventions.

CDC-Unsupported Interventions

All Public Health strategies and interventions no longer supported by CDC for MSM or IDU populations are no longer supported by CDC for MSM/IDU. See pages 6, 8, 22 and 25 for specific interventions.

Locally Developed Intervention with Evidence of Effective

Vibes

Unvetted Interventions

Group Prevention & Support (GPS)
Risk Reduction Counseling (RRC)

Service Requirements and Performance Standards

General Prevention Service Guidelines

Performance Standards for All Risk-Targeted Interventions:

- For risk-targeted grants, at least 70% of clients served in 2015-2016 must disclose a risk prioritized in the *2015-2016 Risk Group Definitions and Points of Consideration*. (See pg 10).

Agency Requirements for All interventions:

Agencies providing HIV prevention services:

- must include an approved recruitment component (outreach, social marketing, risk pre-screening, risk-peer social network recruitment, health communication/public information, internet, etc.) as a part of the intervention cost. Agencies conducting risk-targeted interventions must identify sites or targeting methods likely to reach high concentrations of the each specific Department-prioritized risk populations they apply to serve.
- Must ensure that all counselors conducting any HIV prevention intervention and all users of Provide® database have completed the Department's Confidentiality and Security Training, received a passing score on the training quiz, and taken the Confidentiality and Security oath within the past twelve months.
- Must ensure that counselors conducting any HIV prevention intervention have accurate knowledge about HIV transmission and risk reduction and have completed all Department-required training for the funded interventions.
- Must ensure their counselors provide services competently for a client's risk and culture.
- Must offer clients condoms and other appropriate HIV prevention tools.
- Must receive site authorization and a site number from the Department before delivering services at a new site.
- Are encouraged to develop for each service site a signed Memoranda of Understanding with any site-associated gatekeeper organization demonstrating the gatekeeper's agreement to HIV prevention service promotion or delivery on the premises
- Should preferably document referral collaborations with other service provider organizations in a Memoranda of Understanding to facilitate referrals and confirm referral use
- Must develop and maintain a Quality Assurance Manual including:
  - agency policies relevant to HIV prevention
  - agency protocols for all funded HIV prevention interventions
  - documentation of required training completion for any staff conducting any intervention with training requirements

Staff Requirements for All interventions:

HIV Prevention interventions funded by the Department shall only be provided by counselors who have successfully completed:

- HIV/STD Prevention Core Skills Training
- Risk Reduction Counseling Training
- Confidentiality & Security Training, passing the test and submitting the oath ***annually.***

Documentation Requirements

- Providers must have Provide®-licensed and -trained staff enter intervention sessions and referrals into the Department-approved secure data base. Providers must not permit unlicensed staff to use or enter data in Provide.
- Data for all interventions provided in a given month must be entered into Provide® service reports marked as completed (unless awaiting a confirmatory test result) by the fifteenth of the following month.

Evaluation

Process Evaluation will be monitored through:

- Provide® Reports offering a comparison of service documentation entered into Provide® to contracted scopes of services for each intervention and targeted population.
- Quality Assurance observations of interventions being delivered (or role-played interventions in the case of Surveillance-based Services or Partner Services) assessing the fidelity to service standards of the service conducted biannually by IDPH grant monitors or lead agencies.

Outcome Evaluations may be monitored through:

- a comparison (baseline vs. most recent) of risk latencies (self-reported estimate of the length of time from the session date without an occurrence of the risk behavior) assessed during service delivery for clients served at least two times.
- a comparison of the frequency of reportable sexually transmitted disease diagnoses for an interval preceding the intervention with an interval of similar length following the intervention where client names are confidentially reported
- for prevention for negatives interventions, comparison of HIV antibody/antigen testing results on the session date to similar testing results at a follow up interval to determine whether any new HIV infections have occurred among among clients who tested antigen/antibody-negative at the time of the intervention
- for prevention for positives interventions, comparison of "in treatment" status in the six months prior to the intervention with "in treatment' status in the six months following the intervention as evidenced by documentation of the dates of HIV medical laboratory tests
- for prevention for positives interventions, comparison of the most recent viral load level prior to the intervention with viral load levels conducted at least three months following the intervention.

HIV Counseling, Testing and Referral (HCTR) Guidance

HCTR Performance Standards

- 100% of clients confidentially tested for HIV by a risk-targeted grant will sign a release authorizing the input of the testing record information into Provide® Enterprise for quality assurance review by IDPH and any designated Lead Agency of that region for the grant funding the testing activity.
- At least 1.0% of clients tested for HIV testing through this grant will be newly identified as HIV-positive (i.e. not previously reported as HIV-positive to IDPH HIV Surveillance).
- At least 90% of HIV tests with preliminary positive results will be documented in Provide® Enterprise as *confidential* tests with the required written client consent.

- At least 85% of persons who test preliminarily positive for HIV will receive their confirmatory test results.
- At least 90% of persons who receive their HIV preliminarily positive test results will authorize transmission of their referral information to Ryan White Case Management services (referral) within 72 hrs of receiving their confirmatory result and will attend their first Case Management appointment (linkage) within three months of receiving their confirmatory results.
- At least 80% of persons who receive their HIV preliminary positive test results will authorize transmission of their referral information to medical primary care (referral) within 72 hrs of receiving their confirmatory result and will attend their first appointment (linkage) within three months of learning their results.
- At least 90% of persons who receive their HIV positive test results will be *offered* Partner Services
- At least 75% of persons who receive their HIV positive test results will *participate* in Partner Elicitation and individualized Partner Notification Planning.
- At least 90% of located *partners* elicited from HIV-positive clients identified by certified local health department HIV testing programs shall be offered partner counseling and referral services (PCRS).

HCTR Agency Requirements

All agencies funded to provide HIV counseling and testing (HCTR) services shall:

- Conduct this service according to current Department protocols, as outlined in the Department's HIV Prevention Counseling, Testing and Referral Guidance Manual.
- Ensure that all staff delivering HCTR have completed all training requirements outlined below in H*CTR Staff Requirements.*
- Ensure attendance of at least one agency staff member at any HIV counseling and testing updates offered by the Department and maintain documentation of that attendance.
- Obtain annually and maintain on file a Physician Standing Order from a licensed physician, specifying type of IDPH-approved specimen collected (venous blood, finger stick, or oral) and type of venue (street outreach, mobile, fixed site, etc.) where testing will be conducted.
- Obtain every two years and maintain on file a current CLIA Waiver for IDPH approved for HIV Rapid testing.
    - CLIA Waiver application on line www.cms.hhs.gov/clia
        - click on "how to apply"
    - The IDPH CLIA Waiver Office at 217-782-6747 can also provide assistance.
- Maintain updated written protocols to provide HIV testing to prioritized risk clients.

HCTR Staff Requirements

All HIV counseling testing and referral (HCTR) and Partner Services (PS) shall be provided only by counselors who have successfully completed:

- IDPH HIV Prevention Home study course with a score of 80% or higher;
- An IDPH-approved Fundamentals of HIV Counseling, Testing and Referral Course;
- IDPH Fundamentals II Partner Services (PS) training within 3 months of completion of Fundamentals I

- At least one HIV-related continuing education/skill development course each year with proof of completed course documented in the organization's Quality Assurance Manual.
- Confidentiality & Security Training, passing the test and submitting the oath ***annually.***

HCTR Service Delivery Requirements

- Provide client-centered counseling, testing, partner services and Linkage to Treatment services using the six-step protocol described in the US Centers for Disease Control and Prevention (CDC) document *Fundamentals of HIV Prevention Counseling,* the IDPH Fundamentals of HIV Prevention Counseling, Testing and Partner Services Part I training course, and the Illinois HIV/AIDS Confidentiality and Testing Code.
- Offer HIV testing only to persons 12 years of age or older in accordance with limits on a minor's right to consent granted through the Illinois STD Control Act
- In accordance with FDA-approved kit instructions described in the package inserts,
  - offer OraQuick Advance testing only to persons 12 years and older.
  - offer Clearview testing only to persons 13 years and older.
  - offer Determine testing only to persons 12 years and older.
  - offer Orasure testing only to persons 13 years and older.
- Conduct test counseling sessions *individually* in a *private* setting where discussion cannot be overheard or interactions visually observed by others in the vicinity.
- Note that Prevention Counseling is an integral part of HIV Counseling and Testing which requires no separate service objective. No documentation of or billing for a separate risk reduction counseling session apart from that of the testing record is permitted.
- Include in the pre-test counseling session discussion:
  - HIV transmission and the natural history of HIV infection,
  - the meaning and limitations of the test and test results,
  - the purpose and potential uses of the HIV test,
  - the statutory rights to anonymous testing and to confidentiality,
  - availability of additional or confirmatory testing,
  - the availability of referrals for further information, or counseling,
  - individually appropriate HIV risk reduction methods instruction, including demonstration of proper syringe cleaning, condom use and latex barrier use.
  - assessment of the client's ability to safely cope with a positive test result
  - assessment of the client's HIV exposure risk behaviors including partner risk,
  - assessment of the conditions facilitating or inhibiting risk and risk reduction,
  - identification of safer goal behaviors directly reducing the client's HIV transmission risk
  - identification of action steps the client wants to attempt towards achieving the goals
  - offering of individualized referrals to support the client's specific safer behavior goals
- Use Department-provided rapid HIV test kits in accordance with Department protocols, current CDC guidelines, and FDA-approved manufacturer's package inserts.
- Use whole blood serum testing for conventional or confirmatory testing in accordance with Department protocols when provider capacity setting allows for sterile specimen collection and transport, and proper disposal of sharps or other bio-hazardous materials.
- Use Orasure conventional testing only for confirmation of rapid preliminary positive or rapid indeterminate results.
- Provide directly or offer referrals for syphilis and Mantoux tuberculosis (TB) testing for prioritized risk clients and document referral use

- Provide post-test counseling sessions privately, individually, and face-to-face for all persons who remain or return for their test results.
  - Inform clients of their results, their meaning and limitations.
  - Review the client's prevention plan and referrals offered.
  - Follow up to document referral services accessed.
- For clients with preliminary positive rapid HIV test results, complete the following steps.
  - Request a confirmation test specimen and submit it to the IDPH laboratory
  - Request a written release to immediately submit their contact information and testing record information to the regional Ryan White Case Management Lead Agency or to a competent HIV primary medical care provider of their choice
  - Note that Linkage to Treatment following a preliminary positive result is a part of HIV Counseling and Testing and requires no separate scopes of service. HCTR service units awarded to an applicant agency include the requirement to initiate linkage to treatment when a preliminary positive result occurs.
  - Explain Partner Services options, and initiate a discussion to elicit potentially exposed sex or injecting partners who may need notification if the positive result is confirmed

- For clients with confirmed positive results, complete the following steps.
  - Review Partner Services options, and elicit potentially exposed sex or injecting partners who may need notification.
  - Develop a plan for the notification (client notification, public health notification, assisted notification or contractual notification) of each exposed partner
  - Document contact information for partner(s) elicited from persons testing positive in Provide for partner notification and follow up
  - Provide and document verbal explanation of Illinois law 720 ILCS 5/12 - 16.2 addressing criminal transmission of HIV.

HCTR Documentation Requirements

All agencies shall submit the following to the Department's HIV Counseling and Testing Unit via the Provide® Enterprise system within the time frames specified:

- Electronic submission of required information from a completed HIV Counseling and Testing Report Form before the fifteenth day of the month following the month in which HIV testing was provided or if the client declined to be tested. (e.g., for all clients served in March, data must be submitted by April 15.)
- Document the referrals to Ryan White Case Management or HIV Treatment in Provide® Enterprise.
- Document anonymously tested client records using the Department's client code .
- Forward Partner Service information to Department's HIV Testing Unit on IDPH forms.
- Out-of-jurisdiction exposed partner contacts should be forwarded to IDPH HIV Testing Unit.
- Submit the Initial Interview Record electronically for each client testing positive within ten working days of the actual or scheduled post-test counseling session, and a completed interview record, including all known partner dispositions documented, within 30 days after initial post-test counseling session.
- All testing providers are required by law to report a confidential (but not anonymous) HIV positive test result to the IDPH HIV Surveillance Unit on the IDPH HIV Case report form.

Partner Services (PS) Guidance

Partner Services (PS) involves working with people with HIV disease (PWHIV) upon first diagnosis and on an ongoing basis as needed to elicit and then notify partners potentially exposed through unsafe sex or injection practices of their exposure to HIV, providing risk reduction counseling, HIV testing and referral to needed services.

- Testing-triggered PS is an integral component of the HCTR intervention requiring no separate grant PS service objectives. HCTR service units automatically include initiating PS for testing-identified PWHIV in adherence to Department HCTR policy and procedure manual.
- Surveillance-triggered PS is a stand-alone intervention for which Local Health Departments (LHDs) may request service objectives for partner elicitation and/or partner notification.

Partner Services Performance Standards

- At least 50% of Partners named for public health notification will be notified by the Illinois LHD or Designated CBO with jurisdiction for the named partner's residence.
- At least 50% of notified Partners of unknown status will agree to HIV counseling, testing and referrals.
- All Performance Standards for HCTR apply to Partners tested through PS.

Partner Services Agency Requirements

- Certified LHDs may provide all steps of partner elicitation and partner notification when either testing-triggered or surveillance-triggered.
- Community-Based Organizations may provide partner elicitation but may <u>not</u> provide direct notification of partners of HIV-positive person, unless officially designated by IDPH to do so.
- CBO's may be present as requested by an Index case PWHIV to support or facilitate the client's notification of a partner.
- CBO's should send paper field record referrals of exposed partners elicited during testing sessions to the LHD of the county where the testing session occurred.
- Local Health Departments should develop linkage agreements with local HIV health care providers and related support service agencies able to provide culturally- sensitive and risk-competent care and prevention services of PWHIV and their partners.

Partner Services Staff Requirements

All HIV counselors providing Partner Services for Testing must meet the following training requirements:

- Completion of the IDPH HIV Prevention Home Study course with a score of 80% or higher;
- Completion of the Fundamentals of HIV Testing, Counseling and Referral course
- Assignment by IDPH of an HCTR counselor number;
- Completion of the Fundamentals II, Partner Services training within 3 months of the Fundamentals of HIV Counseling, Testing and Referral training offered by the Department.
- Confidentiality & Security Training, passing the test and submitting the oath ***annually.***

Partner Services Delivery Requirements

- IDPH will refer to LHDs HIV disease cases residing within their jurisdictions which were reported to IDPH HIV Surveillance by physicians, hospitals, laboratories and other health facilities as required by State law. LHD staff will then conduct follow-up with the HIV-positive person to provide partner services, risk reduction counseling and referrals to medical and support services.
- IDPH will also refer to LHDs elicited, exposed partners residing within their jurisdictions reported to the IDPH HIV Partner Services Coordinator on paper or electronic field records.
- Local Health Departments applying to conduct surveillance-based PS should request sufficient service units to include both sessions with PWHIV (for partner elicitation) and sessions with partners (for exposure notification, testing, and risk reduction counseling, and referrals).

Documentation Requirements

- Field records should be generated on each partner named by either a newly HIV diagnosed testing client or by a surveillance- reported PWHIV and forwarded in a confidential manner according to IDPH policy guidelines.
- If a named partner resides outside the county in which the Partner Elicitation occurred, this "Out of Jurisdiction" field record should be sent directly to the IDPH HIV Testing Unit.
- Grant-funded PS providers should assign staff licensed and trained in using the Provide® data management system to enter partner service data triggered by testing or surveillance.

Surveillance-Based Services

In Surveillance-Based Services, the Department refers cases of persons living with HIV Disease whose diagnoses have been reported to HIV Surveillance to an organization authorized by statute or designation to provide services to them. An HIV counselor or epidemiologist then contacts the person to
(1) identify unmet needs for HIV primary medical care, medication coverage assistance, HIV case management and other social services,
(2) securely link the person to individually appropriate services
(3) assist the person to develop a personal, realistic HIV transmission risk reduction plan,
(4) voluntarily elicit the names and contact information of potentially exposed sex or injection drug partners, and
(5) support the client to voluntarily develop and implement a plan to inform each partner that they may have been exposed to HIV.
Case information documented in these encounters then strengthens the accuracy and completeness of Department HIV surveillance records.

Specific details regarding authority, processes, documentation and other requirements may be found in the IDPH HIV Prevention Unit "Surveillance Based Services Protocol".

Linkage to Treatment & Adherence Counseling (LTT/AC) are highly effective and cost effective biomedical prevention-for-positives strategies sometimes called "treatment as prevention." According to the CDC:

> "Treating people living with HIV early in their infection dramatically reduces the risk of transmitting the virus to others, underscoring the importance of HIV testing and access to medical care and treatment. A recent clinical trial showed that treating people living with HIV early on reduces the risk of transmitting the virus to others by 96 percent."

- Surveillance-triggered LTT is a stand-alone intervention for which Local Health Departments (LHDs) may request service units to serve clients diagnosed with HIV typically by other providers but never engaged in HIV medical treatment. The intervention includes educating clients about the importance of early HIV treatment to preserving their health and their community's health, to identify the barriers to treatment engagement for the client.
- Linkage to Treatment & Adherence Counseling involves working with people with HIV disease (PWHIV) identified through IDPH HIV Surveillance records as having been diagnosed with HIV disease at least one year ago with no indication of receiving HIV medical evaluation or treatment as indicated by laboratory-reported HIV Viral Loads or CD4 Counts.
- Surveillance-triggered AC is a stand-alone intervention for which Local Health Departments (LHDs) may request service objectives specifically to counsel services for clients diagnosed with HIV typically by other providers who never engaged in HIV medical treatment.
- Additionally, Surveillance data to help re-link, re-engage persons in care with elevated VL or drop in CD4 counts, or gaps of time without evidence of accessing medical service or updating lab values, and has been activated based on the new Illinois law.

Surveillance-Based Services Performance Standards

- At least 90% of surveillance-reported PWHIV cases referred by the Department through Provide® to Local Health Departments (LHD) or Designated Community-Based Organizations (DCBO) for Surveillance-based Services (i.e. SBS Cases) will be acknowledged and fully investigated by the provider.
- At least 35% of investigated SBS Cases will be located and successfully contacted.
- At least 50% of successfully contacted SBS Cases will participate in a Behavioral Risk Reduction Intervention.
- At least 50% of successfully contacted SBS Cases will participate in Partner Elicitation and Notification Planning.
- At least 0.3 exposed partners needing notification will be elicited per SBS Cases who accepted Partner Elicitation.
- At least 80% of SBS cases contacted who are not currently in HIV medical treatment will complete a first HIV medical care visit resulting in a Viral Load or CD4 count being reported to IDPH HIV Surveillance within 3 months of first contact.
- At least 75% of SBS cases who complete a first HIV medical care visit will report starting Anti-retroviral therapy within 6 months of first contact.
- At least 75% of PWHIV accepting LTT will complete a first HIV medical care visit resulting in a Viral Load or CD4 count being reported to IDPH HIV Surveillance within 3 months of first contact.
- At least 75% of PWHIV in LTT who complete a first HIV medical care visit will report starting Anti-retroviral therapy within 6 months of first contact.
- At least 75% of PWHIV in LTT who start Anti-retroviral therapy will accept an Adherence Counseling session within 9 months of the first contact.
- At least 75% of PWHIV in LTT who start Anti-retroviral therapy will within 9 months of first contact have a second Viral Load laboratory test reported to IDPH Surveillance lower than their baseline VL by at least 1 log.

Surveillance-Based Service Agency Requirements

- Based on legal statutes, Surveillance-Based Services may be provided by Local Health Departments. Community-Based Organizations officially designated by IDPH to do so may also provide Surveillance-Based Services.

Surveillance-Based Service Staff Requirements

All Counselors providing SBS must meet the following training requirements:

- Confidentiality & Security Training, passing the test and submitting the oath ***annually.***
- Surveillance-Based Services Protocol Training
- Risk Reduction Counseling Training
- Fundamentals of Prevention Counseling, Part I and Part II
- Adherence Counseling Training including review of current FDA-approved Anti-retroviral therapies, their side effects, and methods to improve their tolerance.
- Training in HIV Disease Progression and its clinical laboratory markers
- Optional: ARTAS (Anti-Retroviral Therapy and Access to Services) training
- Optional: Individual-Level CDC-supported Diffused Effective Behavioral Intervention for PWHIV such as CLEAR

- Staff assigned to enter data in Provide® are required to be licensed and to receive training in Provide®

LTT/AC Service Delivery Requirements

This form of LTT/AC will follow the protocol below:

- IDPH Surveillance will identify PWHIV with no indication of care in the past 12 months and refer these cases to funded LHD with trained Disease Intervention Staff (DIS) staff.
- Out of care PWHIV will be defined as individuals reported with HIV disease for whom:
  - no reported clinical laboratory VL or CD4 tests have been received by IDPH Surveillance for the past 12 months
  - Ryan White Case Management enrollment is expired or never occurred
  - ADAP and CHIC enrollment are expired or never occurred
- LHD through their DIS staff will contact these out of care individuals to:
  - Assess their current care and prevention needs by conducting a Risk and Needs assessment inventory
  - Identify any barriers to access to care
  - Link consenting individuals to medical care and HIV Case Management
  - Monitor or assist to ensure that consenting client attends to 1st appointment of medical care and HIV Case Management
  - Conduct adherence counseling to increase the probability of successful treatment adherence
  - Deliver individual risk reduction counseling where appropriate using the Fundamentals of HIV Prevention Counseling model or DEBIs prioritized for PWHIV and individually risk appropriate
  - Assess whether the client or their partner is pregnant and refer the woman to PACPI

Documentation Requirements

- Submit LTT/AC service data through the Provide® Surveillance-based Services input screens, recording LTT/AC session data into Provide® by the 15th of the following month.

Risk Reduction Activities (RRA) Guidance

Risk Reduction Activities include (1) Behavioral Interventions to reduce HIV/STI/Viral Hepatitis exposure risk behaviors, (2) Biomedical Interventions to reduce HIV infections from HIV exposures and (3) Integrated Prevention Services such as Sexually Transmitted Infection or Viral Hepatitis risk-targeted screenings and vaccinations to reduce risk through reduced HIV-infectivity of HIV-negative individuals and HIV infectiousness of HIV-infected individuals. Please refer to https://www.effectiveinterventions.org/en/Home.aspx for details regarding specific interventions.

RRA Performance Standards

75% of RRA service units (person-sessions) will be conducted with persons with prioritized risk histories.

RRA Agency Requirements

- Agencies conducting RRA interventions for HIV-positive or HIV-negative persons with prioritized risk must meet *all* of the *General Prevention Service Guidelines* on page 34.
- Agencies must request ***separate*** scopes of services for *HIV-positive* and *HIV-negative* persons (i.e. even if they will participate together in the same intervention) to ensure that sufficient percentage of risk reduction resources reach HIV-positive individuals to comply with new 2012 CDC guidelines.

RRA Staff Requirements

All staff conducting RRA interventions must have:

- Confidentiality & Security Training, passing the test and submitting the oath annually
- Completed the HIV Prevention Home Study Course with a test score of 80% or higher.
- Completed the IDPH HIV/STD Prevention Core Skills training
- Completed the IDPH HIV/STD Risk Reduction Counseling training
- Completed the CDC-approved training for all DEBI's with schedules listed on www.effectiveinterventions.org.
    - ***Note****:* Prior to registering and attending out-of-state training, grantees should check with IDPH staff about potential upcoming DEBI training in Illinois. ***Out-of-state travel must be approved by IDPH prior to a grantee attending the training.***
    - Grantees should be prepared to budget not only travel costs to attend a particular DEBI training, but assess the agency's capacity and assure adequate budget to implement the intervention.
- Completed the IDPH STD Section online training to perform GC/CT urine testing.
- Completed the IDPH STD Section STI Prevention Counseling Webinar to conduct risk-targeted HCV, Syphilis and GC/CT screenings with prioritized populations.
- An MD, NP, PA, RN license in order to administer Hepatitis A&B or HPV Vaccinations. A copy of this license must be provided to the Grant Monitor or Lead Agent for each staff delivering this strategy.

RRA Service Delivery Requirements

- Agencies conducting RRA interventions for HIV-positive or HIV-negative persons with prioritized risk must meet all of the *General Prevention Service Guidelines* Intervention Requirements above.
- All agencies funded to conduct a Risk Reduction intervention (DEBI or locally developed Risk Reduction intervention) must also directly provide or collaborate with another agency to provide onsite, or have referral agreements in place with other agencies to provide approved public health strategies (HCTR, CRCS, STI screenings and vaccinations, Partner Services) to clients receiving the interventions who also need the strategy service(s).
- Awards for IDU prevention services will prioritize agencies which directly conduct comprehensive syringe exchange programs onsite or which partner an agency which provides such collocated services.
- Effective Behavioral Interventions must be implemented with all their core elements. Information on the requirements and expectations of DEBIs can be found at https://www.effectiveinterventions.org/ .
- **Adapting DEBIs to new risk populations**: When Diffused Effective Behavioral Interventions must be adapted to meet the needs of new risk populations or new venue types (i.e., not included in the efficacy studies):
    - CDC guidance requires the following formative program evaluation procedures:
        - Identify intervention components that need adaptation.
        - Collect information to form the procedures and materials.
        - Test the procedures and materials.
        - Document revisions and the data-basis of the revisions.
        - Implement, monitor, and evaluate the revised intervention;
        - Revise implementation materials, as needed.
    - Providers approved to conduct an adaptation of a DEBI must provide the IDPH and where applicable the Lead Agent with a report summarizing the formative and outcome evaluation of the intervention adaptation.
    - Adaptations must maintain the internal logic of intervention's core elements while ensuring cultural relevance and effectiveness for the new population.
    - Intervention specific adaptation must identify the health needs of the persons targeted, as well as their cultural needs and experiences to develop culturally and linguistically appropriate services. Intervention-specific adaptation must competently address the cultural experience of the persons targeted.
    - Intervention specific adaptation must adhere to the Department of Health and Human Service' Office of Minority Health (OMH) published national standards for delivering services that reflect a group's culture and language. This is referred to as culturally and linguistically appropriate services (CLAS). These standards can be accessed at https://www.thinkculturalhealth.hhs.gov/Content/clas.asp.
- Interventions adapted to target bisexual men of color must adhere to the CDC adaptation guide, *Adapting HIV behavior change interventions for Gay and Bisexual Latino and Black Men*.
- Condom distribution to HIV-positives and those at high risk of infection is a highly recommended structural intervention. Condom distribution **must** be accompanied by counseling and/or education or incorporated as an element of an approved behavioral intervention.

- **Unvetted Locally Developed Risk Reduction Interventions** (i.e. interventions not certified as DEBIs) may be funded only when the grant monitor or lead agent determines that delivering a CDC-certified cost-effective or effective intervention to the target population(s) in a high HIV incidence geographic area is not immediately logistically possible due to factors such as lack of staff training in the EBI or the cost of the EBI's implementation exceeding available funds. Then the unvetted or locally developed intervention may be funded with a requirement that the grantee staff must complete training during the project period for a CDC-vetted Effective Behavioral Intervention. The training should be for a CDC-supported cost-effective intervention if feasible and appropriate for the target population, or a CDC-Unsupported EBI if no cost-effective interventions are feasible and appropriate.
    - Agencies funded to implement an unvetted locally developed risk reduction interventions must adhere to the following guidelines:
        - Agencies must create an intervention manual or curriculum that details the intervention objectives, target population, lesson content, learning activities, materials and supplies and other information related to the implementation of the intervention.
            - Agencies may borrow or adapt relevant objectives, lesson plans and evaluation tools from CDC-vetted EBIs with proper acknowledgements in creating a locally developed intervention.
            - The intervention's objectives should be based in the goals of the National and Illinois HIV/AIDS Strategies and the CDC's High Impact HIV Prevention approach. Group Prevention Support (GPS) for PWHIV should focus on improving retention in treatment, medication adherence, partner notification and disclosure, risk reduction methods and negotiation skills, and coping skills.
            - The intervention should be reviewed by target population members to assess target population acceptability and relevance.
            - Agencies must assure the project has a low potential for adverse short- and long-term, individual-level and community-level outcomes that could be attributed to the implementation of the intervention.
            - Agencies should identify the potential for additional health or social benefits that could result from the delivery of the intervention.
        - Agencies must submit in advance of implementation a copy of the intended curriculum and behavioral outcome evaluation instruments to IDPH grant monitor and/or regional lead agent for review and approval.
        - Agencies should allow sufficient time before, during and after the intervention for the collection of data to demonstrate the degree to which the intervention works.
        - For follow up evaluation by the Department, the intervention must be delivered and documented confidentially, not-anonymously, with client verified names and dates of birth documented in the client profile in Provide.

- **Integrated Sexually Transmitted Disease or Viral Hepatitis Prevention Interventions**
    - **Integrated HCV Prevention**
    - Rapid HCV test kits for finger-stick whole blood specimens are available through the Department grantee agencies approved by the Department to conduct this RRA activity.
    - Rapid HCV test kits require a Physician's Standing Order less than 12 months old and a CLIA waiver for Rapid HCV Testing.

- Conventional Hepatitis C testing for phlebotomy serum specimens, though approved for some populations, is no longer supported by the IDPH laboratory. Agencies wishing to conduct this screening will need to contract for laboratory services and obtain a Physician's Standing Order.
- Clients testing positive for HCV by rapid or conventional test should be referred to a physician for clinical evaluation.

- **Integrated Syphilis Prevention**
  - Outreach Targeted Syphilis Screening whether conducted by laboratory processing of venipuncture serum specimen or via an FDA-approved, CLIA-waived new rapid test using finger-stick whole blood specimens requires a Physician's Standing Order less than 12 months old.

- **Integrated Chlamydia and Gonnorhea Prevention**
  - For Prioritized-risk Targeted Outreach Chlamydia/Gonorrhea Urine Screenings
    - Female must have Prioritized Risk ***and*** must be:
      - 25 years old or younger if sexually active
      - 26 years old w/ 1 or more of the following risks:
        - STD signs or symptoms
        - Vaginal discharge
        - Mucopurulent cervicitis (inflammation of the cervix due to infection)
        - Pelvic pain or suspected pelvic inflammatory disease
        - Sex partner of individual diagnosed with Chlamydia and/or gonorrhea
        - High risk sex partner
        - New sex partner in past 3 months
        - More than 1 sex partner in past 3 months
        - STD Diagnosis/History in the past 3 years
        - Pregnant
        - IUD insertion
    - Male with PCPG-prioritized risk must be:
      - 25 years old or younger if sexually active
      - 26 years old with one or more of the following risks:
        - STD signs or symptoms
        - Urethral discharge
        - Dysuria
        - Sex partner of individual diagnosed with Chlamydia and/or gonorrhea
    - If infected with Chlamydia and/or gonorrhea
      - report case to Local Health Department or IDPH STD Surveillance
      - link client to STD treatment
      - re- screen infected three months after treatment to detect re-infection
  - A 3% positivity rate is needed to maintain STD Section approval for this screening

RRA Documentation Requirements

- In order to document Hepatitis A&B Vaccinations in Provide a copy of the staff's MD, NP, PA, RN license must be provided to the IDPH HIV Data Unit to authorize entry of this intervention by that staff person.

Provider Responsibilities

In planning for future services, providers must:

- assess target population community needs and, identify recruitment strategies (outreach, social marketing, social networking, health communication/public information, Internet, etc.) which will engage adequate numbers of the target population as clients.
- document in their application to the Department or Lead Agent their fiscal and organizational capacity to administer and implement all proposed interventions. Grant applicants should identify staff training completed, training needs, and upcoming available training schedules to document preparedness to deliver the intervention within the project period.
- plan for the post-grant sustainability of the intervention given other potential internal and/or external sources of support including insurance billing.

In setting up services, providers must:

- Negotiate scopes of services that are clearly distinguishable from services funded through other local, state, or federal government funds or private funds.
- Submit correct/current contact information of staff providing services to the Grant Monitor or Lead Agent.
- Submit a proposed budget focused on the costs of efficiently delivering the requested service units in a culturally and technically competent manner. All proposed expenses must comply with all applicable federal and state laws including the following.
    - Federal funds may not be used to purchase syringes for injection harm reduction syringe services.
    - Illinois General Revenue Funds may not be used to purchase promotional items including monetary or non-monetary incentives to receive a prevention service.
- Ensure that all project staff have regular access to email and to a computer with word processor software able to import and export Microsoft Word files and a spreadsheet program able to import and export Microsoft Excel files.
- Refrain from utilizing a subcontractor to fulfill any obligations without the prior written consent of the Department and where applicable the Lead Agency.

In service provision, providers must:

- Ensure that all services funded through this service agreement are provided in a manner that is confidential, culturally competent, and appropriate with respect to HIV risk, language, gender, literacy level and ability.
- Ensure that staff conduct themselves in a professional manner while providing services under the context of this grant agreement.
- Ensure that all staff refrain from using alcohol, illicit drugs, or being under the influence of alcohol or illicit drugs while providing any and all services under this grant.
- Adhere to HIPAA and AIDS Confidentiality Act to protect the confidentiality of information reported by HIV prevention recipients, including but not limited to substance use history, sexual history, HIV status, history of STD or other medical diagnoses.
- Maintain signed documentation of collaborative agreements between sites and HIV prevention outreach locations such as nightclubs, infectious disease clinics, methadone clinics, soup kitchens, businesses, etc.

- Immediately place a notice on any applicable website, prominently displayed on the web page(s) most likely to be first encountered by viewers, notifying the potential viewing public that "this site contains HIV prevention messages that may not be appropriate for all audiences." This CDC requirement applies to those recipient web sites funded in whole or part with CDC funds that contain HIV educational information subject to the CDC guidelines, even if the website itself is not funded by CDC. The complete guidelines are available from the CDC website at www.cdc.gov/od/pgo/forminfo.htm .
- Submit all materials for publication for approval by the Regional Community Review Panel (RCRPA) or the Departments community review panel prior to printing, broadcast, or publication. Upon approval from the RCRP or IDPH community review panel, all brochures, booklets, flyers, journal articles, programs, advertisements (including print and out-of-home), multimedia presentations, videos, and other printed or electronic materials (including, but not limited to web sites), prepared with funds from this grant/contract must include the following statement: Funding for this (event, publication, etc.) was made possible by funds received from the Office of Health Protection, Illinois Department of Public Health.
- Deliver interventions as outlined in the agency's work plan, targeting services provided under this grant for promoting and providing HIV prevention services to HIV+ persons and persons at increased risk, defined as MSM (Men who have Sex with Men), HRH (female and male heterosexuals with high-risk behavior or high risk sexual partners), IDUs (female and male Injection Drug Users) and MSM/IDU (males with both MSM and IDU risk history) and as specified in their current work plans

In reporting, providers must:

- Report data on delivered HIV prevention interventions using the Department's Provide® Enterprise system. Data for all HCTR and HE/RR interventions shall be entered to the Provide® Enterprise system by the fifteenth day of the month following the month in which services were provided, (e.g., for all clients served in March, data must be submitted by April fifteenth).
- Submit quarterly reporting to the IDPH Grant Monitor or Lead Agency using the "quarterly report" form and schedule as provided by the Grant Monitor or Lead Agency.

In assuring quality, providers must:

- Require Program managers to attend all of the required biannual site visits and intervention observations scheduled by the IDPH Grant Monitor or Lead Agency.

In planning and coordination efforts, providers must:

- Participate in planning and assessment activities as required by the Department including but not limited to regional needs assessments and resource inventory data collection for the Illinois HIV Planning Group.
- Attend monthly or quarterly grantee meetings facilitated by the IDPH Grant Monitor or the Lead Agency Coordinator.
- Participate in local community forum, focus group, community assessment and community planning activities, as requested by the HIV Section and/or the Lead Agency Coordinator.

In billing, providers must:

- Expend moneys according to the funding level specified in the budget for each line item.
- Request reimbursement from the HIV Section or Lead Agency in accordance with provided instructions and forms and in adherence to the approved current grant or subgrant budget.
- Generate monthly billing by the deadlines stated in the grant agreement using Provide Enterprise® Contract Management system.

Appendix I: Overview of IDPH HIV Prevention Grants

Category A/Core HIV Prevention Services - Regional Grant

Illinois HIV Prevention Regional Grant funds are contracted to lead agencies chosen to fund and monitor sub grantees to implement Regional HIV prevention service plans for prioritized highest risk Illinois residents in each region except Region 9, the City of Chicago. (The CDC directly funds the Chicago Department of Public Health to provide HIV Prevention services in Region 9). IDPH selected HIV Prevention Regional Grant Lead Agencies for Regions 1 through 8 through a competitive application process in December 2011

Regional Service plans have been developed to ensure that in Regions 1-8 as a whole, within each region, and in each service class, service units are distributed by target population so that:

- Prevention service resources are distributed between regions proportionately to recent case distribution between those regions
- service class proportions conform to CDC grant guidelines
- service units are distributed within regions based upon a gap analysis of other HIV prevention services in accordance to CDC grant guidelines
- service units are distributed to prioritized populations by risk by race/ethnicity so that the overall services delivered (for this grant plus others) in the region will be proportionate to recent case regional distribution between those risk groups.

Funds are allocated among Regions by a weighted epidemiologic composite of 90% Incident cases, 5% Prevalent cases and 5% Late Diagnosed Cases(AIDS diagnoses within 0-12 months of HIV-Infection Diagnosis), a formula recommended by the Illinois HIV Prevention Community Planning Group to ensure close correspondence between its priorities and resource allocation.

Gap Analysis attempts to identify in each region those prioritized populations recently *underserved* relative to epidemiologic proportions by HIV prevention services funded by any funding source *other* than the Regional Grant (RG) for which recent service data is available. It then identifies the numbers of RG service units needed to bring the proportion of *total* services (i.e. for all grants combined including RG) delivered to a given prioritized population into alignment with its proportion of the epi. Each RG funding cycle will adjust the recent service profile of other grant streams towards an overall epidemiologically proportioned total.

Additional Applicant Eligibility Criteria for Regional Grants:

- Organizations may apply to provide services outside of the Illinois Region in which they are based (e.g., an agency based in Region 9, Chicago could apply for Region 8 funds to provide services at Regions 8 locations.) However, lead agencies may take into account the travel cost (e.g., staff time and mileage, etc.) if two agencies with an equal likelihood of engaging and effectively serving a prioritized population will have marked different travel costs.
- Organizations may apply to deliver services in more than one region.
- Organizations should generally apply to serve sites within the geographic boundaries of the region for which funded was awarded. Exceptions may be made for a provider to cross regional boundaries to promote or provide a service at a nearby site in a neighboring region with advanced written approval from Lead Agencies of both regions. This boundary crossing

may occur if no other funded providers serve that site and the site is the most efficient means of reaching a target population residing in the funding region. (Example: A Region 6 applicant located near the Region 7 border may propose to conduct HIV Test Counseling at a nearby Region 7 Methadone Clinic not served by other providers because 80% of the clinic's recently injecting clients actually live in Region 6. Prior to awarding Region 6 funds to serve this Region 7 site, the Region 6 Lead Agent would need approval in writing from the Region 7 Lead Agent.)

Category B Redirection Project to Build Capacity for Billing and Reimbursement from 3rd Party Payer Sources (Medicaid, Medicare and Private Insurance) for Routine Testing Providers

This project is a shift for a redirection of supporting HIV Routine Opt-out Testing and supplies provided to multiple health care providers to increase health providers, local health department STD clinics, and other healthcare organizations providing STI / HIV screening services to build capacity that will assist with generating new revenue by billing and reimbursement for these screening services through 3rd party payers sources, including Medicaid, Medicare, and private health insurance. The re-direction encourages HIV healthcare screening providers to leverage other payer sources to cover the costs of HIV screening, thereby freeing up new monies to support dwindling prevention budgets and shortfalls at the agency level. These activities are supported as part of the changing landscape with the Affordable Care Act (ACA)

Category C/Innovative HIV Testing Activities/Enhanced Linkage to and Retention in Care

IDPH has developed a new program, the MSM and Transgender of Color Project. This program will target black and Latino men and transgender persons who have sex with men (BLTMSM). The program includes four components:

- Test and Treat
- Enhanced Disease Investigation Services (EDIS)
- Public Health Professional Capacity Building
- Community-level Treatment Engagement Intervention

Care and Prevention in the United States (CAPUS) Demonstration Project

The CAPUS Demonstration Project is a 3-year cross-agency demonstration project led by the CDC. The purpose of the project is to reduce HIV-related morbidity and mortality among racial and ethnic minorities living in the United States. The primary goals of the project are to:

- Increase the proportion of racial and ethnic minorities with HIV who have diagnosed infection by expanding and improving HIV testing capacity, and
- Optimize linkage to, retention in, and re-engagement with care and prevention services for newly diagnosed and previously diagnosed racial and ethnic minorities with HIV.

The Illinois CAPUS Project includes the following six planned initiatives:

- Expand routine HIV testing in four health systems and six county jails.
- Build a statewide culturally competent Disease Intervention Specialist (DIS) network.

- Transform the Patient Navigator program into a statewide Peer-led empowerment/retention in care program for HIV+ people of color.
- Provide logistical support statewide for retention in care.
- Collaborate with Chicago Department of Public Health and CDC-direct funded programs; align data systems where feasible and possible.
- Launch a youth of color initiative in East St. Louis to co-locate medical (including LGBT health) and other services in a single setting.

Quality of Life

The Quality of Life Endowment Fund was created as a special fund in the Illinois State Treasury. The net revenue from the Quality of Life special instant scratch-off game is deposited into the Fund for appropriation by the Illinois General Assembly solely to the Illinois Department of Public Health (IDPH) to support HIV prevention education and support services for people living with HIV Disease by making grants to public or private entities in Illinois that serve people living with Disease and/or the highest risk populations for acquiring HIV infection.

Grants are targeted to serve at-risk populations in proportion to the distribution of recently reported Illinois HIV Disease cases among risk groups as reported by the Illinois Department of Public Health. The recipient organizations must be engaged in HIV prevention education or HIV healthcare treatment and supportive services.

The grant funds may not be used for institutional, organizational, or community-based overhead costs, indirect costs, or levies. Grants awarded from the Fund are intended to augment the current and future State funding for the prevention and treatment of HIV Disease and are not intended to replace that funding.

General Revenue Fund (GRF)

Monies allocated to the IDPH HIV/AIDS Section in the General Revenue Fund are used to fund proposals for a variety of HIV prevention, surveillance and support services. These include HIV prevention services for persons who are HIV positive, surveillance-based partner services and programming/capacity building to increase service for designated underserved or geographically, unevenly served populations in Illinois. Providers may propose projects that fit one of the following categories:

- Perinatal HIV Prevention Projects
    - Routine First Trimester Testing and Referral coordination with Prenatal care and Labor/Delivery units for expectant and new mothers
    - Enhanced perinatal HIV case management for pregnant HIV+ women

- Correctional HIV Prevention and Care Projects
    - HIV Counseling, Testing and documented Linkage to Treatment and services for correctional populations
    - Peer support programs
    - Evidence-based HIV prevention interventions designed for correctional populations

- Case management service delivery coordination with regional HIV Care Connect offices

- Harm Reduction Projects
  - Syringe Exchange
  - Risk Reduction Counseling with Injecting Drug Users (IDUs)
  - Opiate Overdose Prevention and Reversal

- HIV Prevention Projects
  - HIV Counseling, Testing and Referral (HCT)
  - Group Level Intervention (GLI)
  - Individual Level Intervention (ILI)
  - Comprehensive Risk Counseling Services (CRCS)
  - Partner Services
  - Surveillance-based Partner Services
  - Behavioral and Biomedical Prevention for People Living with HIV
- Projects to support persons living with HIV Disease
  - Core services:
    - Programs to increase medication adherence
    - Programs to ensure linkage and continued connection to medical case management
    - Provision of mental health services
    - Provision or connection to outpatient/ambulatory health services or substance abuse services – outpatient
    - Partner Services/enhanced Linkage to Treatment/retention in care services
  - Support services:
    - Case management services (nonmedical)
    - Child care
    - Emergency financial assistance
    - Food bank/home-delivered meals
    - Housing services
    - Legal assistance
    - Medical transportation services
    - Case finding/Outreach
    - Psychosocial support services/disclosure support
    - Rehabilitation service
    - Support Groups for HIV positives
    - Risk Reduction for HIV positives
    - Individual and Group therapy for discrimination and Stigma reduction
    - Early Intervention services (e.g. *timely Linkage to Treatment for newly identified positives and those lost to care and follow up, support for serodiscordant couples, group support for incarcerated individuals who are reentering the community, peer education/support services*)